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ABSTRACT

This is a research report and survey on drug abuse in Montgomery County, Norristown, Pennsylvania, conducted by the Montgomery County Drug Commission. The nine-month study is incorporated into a single volume. An analysis of the results of the drug survey points out that many variables which had heretofore been regarded as being significantly related to drug abuse have not proven significant in the scientifically conducted Montgomery study. No evidence was found of significant correlations between drug abuse and race, sex, ethnicity, parental education, family size, position of sibling in family, and number of parents at home. From this study, the general use of drugs is seen as cutting across class, race and ethnic groupings. Certain other variables have shown themselves as being significantly related to drug abuse. They are as follows: lack of family closeness or cohesiveness; lack of religious attachment; peer group influence; discontent with school; boredom; and influential relationships with siblings and close friends. The volume also reports historical data, research findings, drug services, and findings and recommendations. (Author/WS)

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MONTGOMERY COUNTY DRUG COMMISSION

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DRUG ABUSE

MONTGOMERY COUNTY

PENNSYLVANIA

November 29, 1971

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November 29, 1971

Board of County Commissioners
Montgomery County Court House
Norristown, Pennsylvania

Gentlemen:

On behalf of the Montgomery County Drug Commission, I hereby transmit for your review and consideration the completed research report and survey on drug abuse in Montgomery County. The report has been incorporated into a single volume and is divided into eight sections which we believe to be the key elements of the drug abuse syndrome.

This nine-month study provides factual knowledge for your use. It is the earnest belief of the Drug Commission that this study will provide you with the information and direction necessary for County government to effectively begin to assist its citizens with the problem of drugs.

We wish to express to you our sincerest gratitude for your wisdom and insight in appointing this Drug Commission and extend our appreciation for providing the materials necessary to accomplish this task.

Respectfully,

Andrew L Lewis Jr

Andrew L. Lewis, Jr.
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The Montgomery County Drug Commission extends its sincerest appreciation to the following persons who appeared before the Commission and whose expertise and knowledge have proven invaluable to the Commission's efforts:

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FOREWORD

The experiences of the past year have been rewarding and frustrating for the Montgomery County Drug Commission--rewarding in the sense that we have have had an opportunity to review a very complex social problem and to make recommendations relative to its cure--frustrating in that the complexity of the problem grew with our understanding. Although in our judgment, our recommendations are valid based on our present understanding, they are in no means sufficiently comprehensive to be considered complete. Further study is required with greater involvement of people with technical competence to implement the ideas documented herein.

In our judgment, the composition of the membership of the Drug Commission proved to be a proper mixture. The obvious contradictions in testimony provided by the information brought to us through interviewing experts, visiting various types of drug facilities, and voluminous readings were more easily brought to perspective by a lay committee. The variance in ages, ethnic backgrounds, and life styles of the committee also provided a healthy balance when evaluating data.

The Commission is most appreciative of the open cooperation received throughout the entire community. Many hours of testimony were provided by experts in the drug field. The County Commissioners stayed close to the problem through regular attendance at almost all of our sessions. The County schools provided valuable insights into the drug situation in the County through the research survey. The professional staff working with the Commission donated many hours beyond a normal work day to complete this study within a limited time. The attendance of the Commission members to meetings, consuming many Saturdays, evenings, and field trips during the week, was most gratifying. In short, the response to a concern for drug abuse was in keeping with the severity of the problem.

Although it is difficult to express particular appreciation to only a few individuals, we would like to thank County Commissioners A. Russell Parkhouse, Frank W. Jenkins, and Daniel T. Costello for the opportunity to serve on the Commission and for the staunch support they have provided. The Commission is most grateful to Hilory G. Oliver, Jr., our Executive Director, who has worked night and day as an employee and volunteer to complete this study with a great sensitivity to the people with whom we have worked and to the problem of drug abuse. Montgomery County is fortunate to have a professional staff member with Hilory's devotion.

As chairman, I thank the members of the Commission for the opportunity provided me to serve as their chairman and for their diligence in pursuing this project. It has been one of the most gratifying and, at the same time, disturbing experiences of my life.

Andrew L Lewis Jr.

Andrew L. Lewis, Jr.
Chairman

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INTRODUCTION

Since the inception of the Montgomery County Drug Commission in December of 1970, there has been a constant effort to obtain and record systematic data on the drug abuse problem. This study was initiated by the County Commissioners when it became apparent that the casualty rate of drug abusers was growing at an alarming speed. Most County human service agencies were reporting increases in drug referrals. Additionally, several communities had requested specific action to help them stem the tide of this insidious social infection. The District Attorney had reported that as of January, 1970, 167 persons had been brought before the court on drug charges for that year. In addition, as of December 30, 1970, a backlog in criminal cases of 2,470 had accrued and approximately 20 to 25 percent represented some type of drug offense. The Chief Juvenile Officer had reported that in 1970, a total of 210 male children and 46 female children had been referred to the Juvenile Court for narcotic and nonnarcotic drug offenses. A review of the Coroner's records for the County indicated that in 1970, 24 County residents died as a result of drug abuse either through accidental or suicidal means.

All agencies had reported a substantial increase over the statistics of 1969, and the obvious statistical trend showed a marked increase in the use of drugs by citizens in our County. In view of this, the County Commissioners decided that the County must try to respond to the communities' needs. It was clear that before any course of action could be taken, an in-depth review of the problem had to be conducted to identify, as clearly as possible, the scope and depth of drug abuse. Initially, the Commission was charged with the responsibilities of identifying the type and amount of drug abuse occurring in Montgomery County, and to then determine what facilities were presently available to deal with that problem. However, it soon became apparent to the Drug Commission that these two objectives represented only one part of a very complex problem. The Commission was going to have to look beyond the symptoms of drug abuse itself if any meaningful approaches for dealing effectively with the problem were to be developed. In essence, knowing the size of the problem did not provide enough data for determining what caused it or how to most effectively deal with it. The Commission saw its purpose as not only providing information as to what role the County could best play, but also to recommend programs which would help identify and deal with the roots of drug abuse behavior. Thus, a third objective was adopted by the Commission which addressed itself to the need for identifying causality factors for drug abuse and suggesting programs which would be meaningful in changing these factors.

Since December of 1970, the Drug Commission has heard testimony from 66 persons who are in some way working on the drug problem.

The majority of these witnesses were from Montgomery County and addressed themselves specifically to local problems. In each and every case, the recommendations for certain needs were repeatedly reported by these witnesses. In addition, it was constantly emphasized by various witnesses that drug abuse behavior was only a symptom, and that the Commission must look beyond this symptom if any effective changes were going to be realized.

After three months of study, the Drug Commission submitted to the County Commissioners three interim recommendations for immediate consideration. These recommendations were supported by Commission testimony, community calls to the Commission, and the Drug Commission's own findings and conclusions.

The three recommendations were as follows:

1. To investigate the feasibility of creating a 24-hour emergency reception center to service all citizens in the County of Montgomery with a drug problem.

2. To endorse and fund the establishment of an outpatient methadone clinic within the County of Montgomery for the purpose of treating heroin addicts, and that this treatment modality be seen as another approach to meeting the needs of addicted persons and not as the total answer to treatment of drug abusers.

3. That the County of Montgomery retain the services of SRI-Human Systems Institute to conduct a County-wide survey for the purpose of obtaining data in the following areas:

    a. A statistically determined measure of the number of young people in the County who were using drugs.

    b. An assessment of the type of drugs used by County youths.

c. An assessment of attitudes towards drugs held by County youths.

d. Causality factors for drug use.

e. Identification of those communities where drug abuse was most seriously reflected by arrest records, survey results, and medical referrals.

f. Other related sociological and demographic data relating to the drug abuse syndrome.

In addition to the above steps, the Drug Commission immediately saw the need to go into the community for direct interviews with treatment facilities now in existence. As a result, the Commission formulated three subcommittees and proceeded to visit various established treatment programs in Delaware Valley and New Jersey. This approach allowed the Commission members to see the realities of program treatment problems and provided them with a direct understanding of the treatment models now being utilized. In all cases, the committees reported back that this approach had proven very meaningful in helping them to fulfill the task charged by the County Commissioners.

In summary, the Montgomery County Drug Commission has attempted to complete its objectives as quickly as possible. It has, since its inception, been cognizant of the increased rate of drug abuse and the need for immediate action. However, by taking the time to study the problem, the Commission has been able to come forward with recommendations to the County Commissioners that are based on sound fact and knowledge of what is happening at this time. The Commission's desire to act promptly was reflected by its endorsement of a methadone program and its recommendation for an emergency reception center. In both cases, the Commission gathered sufficient supportive data to warrant these recommendations and thus moved forward on them. At present, a methadone model has been approved by the County Commissioners, and hopefully that program will soon become a reality. In the matter of the emergency reception center, the County Commissioners have instructed the Mental Health-Mental Retardation Board to begin investigating with the Drug Commission the possibilities of developing such a unit within the next few months. In regards to the survey, its findings are enclosed in this report and, in part, form the basis for the Commission's recommendations.

The Commission has carefully studied all testimony and in each area of concern, has attempted to report on those specific services which will most effectively provide to the County a meaningful approach to the drug abuse syndrome. It is the Commission's desire that all recommendations pertaining to any one area will be reviewed by those professionals in that field and expanded on as they see fit in terms of the reality of their capacities. It should be noted that the Commission, because of the massive amount of information in the various areas, did not attempt to develop total programs but only wished to provide the nucleus of those elements which would ultimately be the seeds of truly tailored services. It is the Commission's intent that the following pages will be the beginning of the demise of drug abuse.

HISTORICAL REVIEW

From time immemorial, behavior-affecting and mind-altering drugs have been used, prescribed, and recommended for their tension relieving capabilities. Many cultures used drug preparations in religious rites. Relative to the span of history, only recently have some drugs been outlawed.

Marijuana's effects were known as far back as 2700 B.C. when Emperor Shen Neng of China recommended marijuana for gout, constipation, and "absent mindedness." Primitive peoples were familiar with such agents as opium, cocaine, and hashish to induce states of intoxication during religious rites.[1]

Coca has been used in the Andes by the inhabitants for centuries as a stimulant while performing heavy labor. When taken in leaf form, the cocaine content is so small as to compare with coffee drinking in this country. Coca was mixed with wine in France to make a popular beverage known as vin coca mariana during the 19th century. It was also an ingredient of Coca-Cola until 1904 when it was prohibited by the Federal Government.[2]

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[1] Drug Abuse: Escape to Nowhere (Philadelphia: Smith, Kline & French Laboratories, 1968), p. 16.

[2] Richard R. Lingeman, Drugs from A to Z: A Dictionary (New York: McGraw-Hill, 1969), pp. 43-44.

Peyote was in use in South and Central America before the advent of recorded history. The Aztecs considered it divine, and in remote areas Mexican Indians continue to use it as a vehicle for communicating with divine spirits. The Native American Church which is an organization of American Indians use it in religious ceremonies protected by law.[3]

Opium was known as far back as 1500 B.C. by the Egyptians and was the most important of these substances from a medical standpoint. During the Greco-Roman period, opium was used for sleep-inducing and pain-relieving properties. Opium intoxication had the power to allay fear, gloom, and despair. In Homer's Odyssey written in the ninth century B.C., opium was referred to as "a drug potent against pain and quarrels and charged with the forgetfulness of all trouble; whoever drank this mingled in the bowl, not one tear would he let fall the whole day long, not if mother and father should die, not if they should slay a brother or a dear son before his face and he should see it with his own eyes."[4]

By the 18th century opium was used in the American colonies by physicians as a therapeutic agent. Doctors advocated its use as an analgesic in venereal disease, cancer, and dysentery. In 1791, one Hast Handy proclaimed in his medical thesis that opium and alcohol were similar in effect and therefore saw no reason why broader use of the drug could not be made. Benjamin Rush, a physician and signer of the Declaration of

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[3] Ibid., p. 198.

[4] Drug Abuse, Escape, p. 16.

Independence, recommended the opium be used for treatment of typhoid fever and "in all those fevers where wine is safe or proper." Thus, it must be stated that in the 18th century when medicine was in the stage of breaking out of infancy into the modern era, opium was improperly understood, and its addiction properties were not recognized.

Opium addiction was further complicated by the discovery of opium alkaloids; morphine in 1805 and codeine in 1832. Physicians, who had just begun to realize the addictive dangers of opium, could not see the connection between opium and the potential hazards of these derivatives. In terms of potency, morphine became popular since one grain of morphine had an analogous effect of 10 grains of opium. The invention of the hypodermic needle in 1843 only increased the possibilities for administration of the opiates and led to further spread of addiction.[5]

Morphine was used widely in the Civil War for pain relief of battle wounds and dysentery. Vast numbers of soldiers afflicted with what was termed "Soldiers Disease" returned to civilian life addicted to morphine. Subsequently, various forms of opium and its derivatives to be taken orally were available commercially after the end of the Civil War. These included laudanum which was a mixture of one grain of opium to 25 drops of alcohol, paregoric which was one grain of opium to 480 drops, and Dover's powder which was opium mixed with ipecac and milk sugar. Opium was smoked, a practice introduced to San Francisco by Chinese laborers after the California

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[5] Ibid., p. 17.

Gold Rush. Opium was also pulverized for use as suppositories and morphine was administered orally, rectally, and hypodermically.[6]

In 1898, heroin was synthesized and was proclaimed a major breakthrough in the treatment of morphine addiction. Initially considered non-addictive, it created addicts by the thousands according to some sources.

During the 18th and 19th centuries, the medical view of opiate addiction had been ambivalent and capricious. Physicians often regarded opiate addiction and alcoholic addiction in like manner. Some doctors saw no connection to addiction at all, and therefore saw no reason to regulate administration while others conceded that consequences resulted from opiate use, but determined there was no effective treatment of the "opium disease." Others felt that opium did not affect all races alike. One writer stated that opium "seldom intoxicates the European; it seems habitually to intoxicate the Oriental. It does not generally distort the person of the English or American; in the East it is represented as frequently producing this effect."[7]

Although it is alleged with much justification today that opiate indulgence has its roots in the urban ghetto community, this was not true in the 19th century. Use and abuse of opium and derivatives cut across economic and social lines, but was most prevalent in the middle and upper middle classes. The exception to the rule, of course, was opium smoking, an indulgence of the Chinese which were lower class.[8]

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[6] Ibid., p. 18.

[7] Horace B. Day, The Opium Habit, 1868 as cited in Drug Abuse: Escape, p. 19.

Opium eating was an upper class obsession as distinguished from opium smoking. The most prominent people addicted to opium without realizing its dangers were authors Thomas De Quincey (Confessions of an English Opium Eater), Edgar Allan Poe, Francis Thomas, Samuel Taylor Coleridge and composer Modest Moussorgsky. Thousands of other prominent people in social and literary circles were addicted to opiates. If not addicted, thousands of others had at their disposal quantities of gum opium, tincture of opium, paregoric, and others.[9]

Gradually, a change occurred in the public attitude toward narcotic addiction for the following reasons:

1. Physicians became aware of the evil wrought by narcotics, but they did not set about to morally condemn addicts.
2. Some states tried to legislate against narcotic addiction as early as 1862.
3. Physicians took to criticizing the destructive nature of drug-dependent persons.
4. The newspapers started sensationalizing the accounts and personal stories of addicts and physicians treating them.
5. The result was a polarization of the controversy through information and misinformation available. Some saw addiction as an illness while others found it a vice. However, narcotics could still be purchased legally. Thus there was no connection between addiction and criminal behavior.[10]

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[8] Ibid., p. 20.

[9] Ibid.

[10] Ibid., pp. 20-22.

The first federal attempt to control narcotic addiction came in 1909. This was an act to prohibit the importation of opium and its derivatives except for medical purposes. By 1912 many cities and every state but one had laws regulating the prescription and selling of narcotic drugs, but they were not vigorously enforced. Hence, it was still possible to purchase opium and its derivatives at pharmacies.[11]

The Harrison Act of 1914 originally set out to regulate the production, distribution, and manufacture of narcotics through the registration and payment of an occupational tax by all parties concerned. However, subsequent court decisions further restricted and limited the right of physicians to prescribe narcotic drugs.[12]

From 1913-1923, 40 outpatient clinics to treat narcotic addiction opened, but were closed because it was felt that drug dispensing as a part of treatment from these units was too lax and that it hindered recovery.[13]

This is the point at which the underworld made inroads into the narcotics traffic. Addicts cut off legally and clinically from drugs turned to illicit sources of supply. Naturally enough the general public soon linked narcotics addiction with crime. The Supreme Court did little to aid rehabilitation. It focused instead on stiffer penalties.

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[11] Ibid.

[12] Lingeman, Drugs from A to Z, p. 91.

[13] Drug Abuse: Escape, p. 23.

In 1915, the Court decided in U.S. vs. Jim Fuey Moy, 241 US 394 that possession of smuggled drugs by an addict was a violation of the law. The Harrison Act had required only that the drugs received by addicts must be from a registered physician. However, the Court ruling had the effect of expanding the Act's meaning which had not before specifically outlawed possession of narcotics.[14]

In other cases in 1919, 1920, and 1922 the Court declared that physicians who prescribed drugs to addicts to keep addicts from suffering the effects of withdrawal were not under the protection of the law. Prescription of small amounts as part of the course of professional treatment in attempting to cure the addict was allowed. However, in one conviction in 1925, a physician was prosecuted for selling four tablets of opium to a police informant. In overruling the lower court decision, the Supreme Court in Linder vs. U.S. stated that the amount prescribed was insignificant and was not a flagrant abuse of the doctor-patient relationship.[15]

Encouraged in part by the Supreme Court, the public, and the Harrison Act, narcotics officials reasoned that to stamp out the immorality of narcotics addiction the addict had to be treated primarily as a criminal and secondarily as a sick person. Hence, Congress passed legislation in 1929 for the construction of two high security addiction treatment centers to be located in Lexington, Kentucky and Fort Worth, Texas.

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[14] Alfred R. Lindesmith, The Addict and the Law (New York: Random House, 1967), p. 5.

[15] Ibid., pp. 6, 8.

In 1931, the Federal Bureau of Narcotics was created to augment law enforcement efforts on the state and local level. It now has 300 agents in the field with an annual budget of six million dollars. Its functions are to investigate, detect, and prevent violations of the law regarding opium, opium derivatives, cocaine, and marijuana which are all classified as narcotics. The Bureau also regulates importation of crude opium for manufacture into morphine.[16]

Marijuana smoking was introduced to the United States in the early 1900's by Mexican laborers and by merchant seamen of Latin American descent into New Orleans in the 1920's. State authorities ignored the practice for the most part until the 1930's when lurid stories depicted the increase in crime on children high on the "muggles."[17]

During World War II, marijuana was grown in the United States for its hemp content. Strong fibers were obtained only from the male plant. The marijuana hemp was grown in the United States because the principal source of hemp from Manila was cut off by Japanese conquest of the Philippines. However after the war, production of domestic hemp was once again curtailed. At the same time, the spread of marijuana increased steadily among Negro and Latin American musical subcultures.

In the 1950's marijuana smoking had found its way into the lower classes in the center city, intellectuals, literary, and jazz circles. This quaint alliance promulgated marijuana on the college level by the 1960's. By the end of the 1960's, marijuana use had reached into the secondary schools.[18]

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[16] Lingeman, Drugs from A to Z, p. 31.

[17] Ibid., p. 144.

The Marijuana Tax Act of 1937 was modeled after the 1914 Harrison Act in that buyers and sellers of marijuana were required to register and pay a tax on the quantity of marijuana purchased as a matter of record. This Act came about after a brief hearing before a subcommittee of Congress and was then passed by the whole body with little discussion. Marijuana had become a matter of public concern, thanks to the chief of the Bureau of Narcotics who had waged a publicity campaign for several years prior to the enactment of this legislation.[19]

The efforts of the Bureau of Narcotics were aided by one Earle Albert Rowell, "a hyperactive reformer and alarmist of the period." While objecting to alcohol with strong fervor, Mr. Rowell also condemned tobacco which he alleged would lead young and old alike down the path to the "deadly reefer."[20]

Mr. Rowell stated the following about marijuana:

"We know that marijuana--

1. Destroys will power, making a jellyfish of the user. He cannot say no.

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[18] Ibid., p. 145.

[19] Lindesmith, The Addict and the Law, pp. 228-230.

[20] Ibid., p. 228.

2. Eliminates the line between right and wrong, and substitutes one's own warped desires or the base suggestions of others as the standard of right.
3. Above all, causes crime, fills the victim with an irrepressible urge to violence.
4. Incites to revolting immoralities, including rape and murder.
5. Causes many accidents both industrial and automobile.
6. Ruins careers forever.
7. Causes insanity as its specialty.
8. Either in self-defense or as a means of revenue, users make smokers of others, thus perpetuating evil."[21]

In 1943, Mayor La Guardia of New York City created a Committee on Marijuana which tested the effects of marijuana on 77 prison inmates. Its findings determined that the drug was relatively harmless and that legislation against the drug was ill-advised. The report issued in 1945 stated that, "The smoking of the leaves, flowers, and seeds of Cannabis sativa is no more harmful than the smoking of tobacco or mullein or sumac leaves."[22]

The La Guardia Committee report was attacked editorially by the Journal of American Medical Association arguing that the report had been the justification for a number of young people to "turn on," had stimulated drug peddlers in the plying of their trade, and had irreparably damaged the efforts of law enforcement.[23]

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[21] E. A. Rowell and R. Rowell, On the Trail of Marijuana, pp. 69-74 as cited in Lindesmith, The Addict and the Law, p. 229.

[22] Ibid., p. 234.

[23] Ibid., p. 236.

Although the Federal Bureau of Narcotics grew continually in size through the 1940's and 1950's marijuana arrests, despite official dogma, continued to decrease after 1952. The high point for federal arrests was 1,288 in 1952. By 1958 the number had dwindled to 179. As the federal agency increasingly devoted its attention to "hard" narcotics detection, most states had adopted marijuana laws in line with the federal laws and had taken up the struggle against marijuana through local law enforcement efforts.[24]

The La Guardia Committee report today is generally thought to be defective in two ways. Only 77 people were tested which by today's standards is not a representative sample. Also, the researchers tested the effects of eating marijuana, not smoking it.[25]

If federal efforts for marijuana became lax during this period, efforts against hard narcotics became more harsh. Congress in 1956 passed the Narcotic Drug Control Act. This raised the mandated minimum penalty for a first violation of the Harrison Act to five years with no possibility of probation or parole.[26]

The White House Conference on Narcotics and Drug Abuse in 1962 disclosed some new attitudes on the drug subject. The conferees determined that the narcotics addict is not only a criminal but a sick person who suffers from "an inadequate personality...unable to cope with the stresses of normal life."[27] The director of the Bureau of Prisons described the difficulty he was experiencing in rehabilitative efforts of addicts. He stated that most addicts were wholeheartedly indifferent to courses in academic or trade training.[28] Public attention has also been focused on a growing trend toward abuse of nonnarcotic drugs such as amphetamines, barbiturates, tranquilizers, and hallucinogens, notably LSD-25.[29]

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[24] Ibid., p. 237.

[25] Coles, Brenner, and Meagher, Drugs and Youth (New York: Liveright, 1970), p. 157.

[26] Drug Abuse: Escape, p. 23.

In 1962, the Supreme Court reaffirmed that an addict was a sick person. The Court overturned a California law that made it a criminal offense to be addicted to the use of narcotics. The justices declared that it was unlikely that any state government would attempt to make those suffering from mental illness, leprosy, or venereal disease criminals. To urge and provide rehabilitation was reasonable, but making a disease a criminal offense was cruel and unusual punishment.[30]

In 1963, the President's Advisory Commission on Narcotics and Drug Abuse noted the relative safety of marijuana as mode of criminal behavior by recommending that all mandatory sentences be eliminated for crimes involving it, and that judges be given full discretionary power in dealing with offenders.[31] In 1965 Congress, proceeding from a recommendation by the Commission, amended the Food, Drug, and Cosmetic Act of 1938 to bring distribution of amphetamines, barbiturates, and other abused drugs under the Food and Drug Administration's control.

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[27] Ibid., p. 24.

[28] Nat Hentoff, A Doctor Among the Addicts (New York: Rand-McNally, 1968), p. 35.

[29] Drug Abuse: Escape, p. 24.

[30] Hentoff, A Doctor Among the Addicts, pp. 38-39.

New, meaningful legislation was forthcoming in 1966 with the passage of the Narcotic Addict Rehabilitation Act. This Act further enhanced the view that "narcotic addiction was symptomatic of an illness that should be treated and not a criminal circumstance in itself." It provided for civil commitment in lieu of prosecution on the federal level and provided grants to state and local governments among other things.[32]

In 1970, Congress passed into law the Comprehensive Drug Abuse Prevention and Control Act. This law provides "increased research into, and prevention of, drug abuse and drug dependence" (addiction has been replaced by the term dependence). It provides "for treatment and rehabilitation of drug abusers and drug-dependent persons and strengthens existing law enforcement authority in the field of drug abuse."[33]

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[31] Lindesmith, The Addict and the Law, p. 240.

[32] Narcotic Addiction Rehabilitation Act, National Institute of Mental Health, 1966, National Clearinghouse of Mental Health Information, pp. 1, 2, 5.

[33] Public Law 91-513, 1970, U.S. Government Printing Office, p. 1.

HABITUATION, DEPENDENCE, ADDICTION, AND CLASSIFICATION OF DRUGS

Drugs are chemical substances that have an effect upon the body and/or mind. Many drugs are beneficial if used properly. Many medications are sold on the open market for relief of headache, body ache, neuritis, neuralgia, etc.

Some drugs have no known medical benefit or are detrimental when used improperly. By and large, those drugs which radically alter motor activity, organ function, or mental perception are illegal or prescription medicines, or utilized only in sanctioned experimental studies.

Some drugs react in the body with a pleasurable effect. Sometimes when pleasure is derived from drugs, they become physically or psychically necessary. To the degree that this phenomenon occurs, drug use may be classified into three categories: habituation, dependence, and addiction.

Habituation is a normal characteristic of the human condition. People are creatures of indulgence and tend to repeat acts which have significance, expedience, or pleasure. People fall into ruts. They take the same route to work every day, mow the lawn the same way every week, smoke the same cigarettes every day, and so forth. Drug habituation includes the following characteristics: (1) an urge (but not a compelling urge) to continue ingesting a substance for the sense of improved well-being it engenders; (2) there is no tendency to increase the dose; (3) some degree of psychic dependence but tolerance to the drug increases very little; (4) detrimental effects are on the individual as opposed to society.[1]

Coffee drinking and cigarette smoking are prime examples of drug habituation. Smokers say they continue to smoke because it helps to calm their nerves or gives them something to do with their hands. Although smokers tend to increase the number of cigarettes they smoke, it is not a rapid increase. In comparison to heroin addiction, there is not as large an increase in the amount ingested. Although nicotine is stored in the tissues of the body, abstinence from cigarettes does not create a great degree of discomfort for the ex-smoker. The risks of smoking are borne by the individual who may get lung cancer, not society at large which is only indirectly affected.

Dependence is differentiated from habituation in that it is implied that without the drug's support, the individual would suffer a state of disequilibrium. Dependence has two components: psychological and physical. With habituation there is some degree of psychological dependence and little or no physical dependence. However, dependence as a term implies that the physical need for the substance outweighs the psychological need.[2]

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[1] Richard R. Lingeman, Drugs from A to Z: A Dictionary (New York: McGraw-Hill Book Company, 1969), p. 88.

In 1964, the World Health Organization's Expert Committee on Addiction-producing Drugs defined drug dependence as follows:

> "Drug dependence is a state of psychic or physical dependence, or both, on a drug, arising in a person following administration of that drug on a periodic or continuing basis. The characteristics of such state will vary with the agent involved, and these characteristics must always be made clear by designating the particular type of drug dependence in each specific case; for example, drug dependence of morphine type, of amphetamine type, etc."[3]

Addiction is an overpowering involvement with, and longing for, a chemical substance accompanied by physical dependence which motivates persistent usage. Addicting drugs cause the human body to form a "tolerance" which negates the effect of the substance. Hence, additional amounts of the drug are needed to obtain the desired effect. When the drug is no longer ingested, the body reacts in such a way as to provide readily identifiable symptoms. These symptoms, known as the withdrawal syndrome, are quite severe. This is one of the greatest dangers of addiction. A person habituated to cigarettes may feel nervous or edgy when he quits, but withdrawal from heroin is physiologically painful.

The effect of the addiction-producing drug is so powerful that the individual orients his life around acquiring it at whatever cost to himself or society. A person is truly addicted when he acquires the drug not to get high but just to feel "normal." Addiction is also characterized by a high rate of relapse after the addict has been detoxified from the substance. This addiction encompasses psychic properties as well as physical properties. Because of the notorious meanings that the word (addiction) began to imply, the World Health Organization in 1964 recommended that the term "drug dependence" be substituted for "drug addiction."

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[2] Robert Coles, Joseph H. Brenner, and Dermot Meagher, Drugs and Youth (New York: Liveright, 1970), p. 12.

[3] Lingeman, Drugs from A to Z, pp. 58-59.

Drug Abuse/Drug Addiction

Drug abuse and drug addiction are not synonymous terms. Drug abuse may be defined as the ingestion in excessive amounts of a chemical substance although the intake of the drug is not necessarily a repetitive act. Drinking too much beer or alcohol to the point of drunkedness may be termed drug abuse. Smoking cigarettes to the point of headache or nausea or taking 20 aspirin to pass out are also examples. Of course, drug abuse also encompasses the use of illegal drugs like marijuana, amphetamines, barbiturates, LSD when these are used on an occasional basis.

Drug abuse becomes drug addiction when (1) use of a drug has the capability of creating a physical dependency through body tolerance, (2) the individual uses the drug on a regular basis above and beyond infrequent recreational use. A person is addicted to a drug when he relies on a drug to feel normal, and when acquiring and using the drug becomes a central activity in his life.

Classification of Illicit Drugs[4]

Central Nervous System Stimulants

- Nicotine
- Caffeine
- Amphetamines:
  - Benzedrine
  - Dexedrine
  - Methedrine
- Cocaine

Central Nervous System Depressants

- Alcohol
- Barbiturates:
  - Luminal
  - Nembutal
  - Seconal
  - Amytal
  - Tuinal
- Other Sedatives:
  - Doriden
  - Placidyl

Psychotropics

- Major Tranquilizers:
  - Mellaril
  - Thorazine
- Minor Tranquilizers:
  - Miltown
  - Equanil
  - Librium
  - Valium
  - Serax

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[4] Richard Brotman and Alfred Freedman, A Community Mental Health Approach to Drug Addiction (Washington: U.S. Government Printing Office, 1966), p. 43.

Natural Hallucinogens

LSD
Marijuana
Psilocin (Psilocybin)
Mescaline

Synthetic Hallucinogens

DMT
STP
MDA

Opiates

Natural Opiates:
- Opium
- Morphine
- Heroin
- Codeine
- Pantopon
- Dilaudid
- Numorphan
- Laudanum
- Paregoric

Synthetic Opiates

Dolophine (Methadone)
Demerol (Meperidine)

Note: The above drugs represent common examples in each category.

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CENTRAL NERVOUS SYSTEM STIMULANTS

Nicotine and caffeine are substances used by many people, few of whom think of these as drugs. Psychologically, many people identify their use as a pleasurable habit. Central nervous system stimulants excite motor activity, respiration, heart rate, and blood pressure. Toxic overdoses of the above drugs have never been reported.

Nicotine and caffeine are important for consideration here in that they should be identified as drugs. When placed in that perspective, it is not as difficult to believe that other drugs will be taken for granted and then abused. (It is charged by some that tobacco use is a stepping stone to marijuana.)

Amphetamines are synthetic amines which act with a pronounced stimulant effect on the central nervous system. They are similar in action to adrenalin which is secreted in the human body when the individual is under stress. Medically, amphetamines have been used in the treatment of narcolepsy which is characterized by sudden attacks of sleep and weakness. Sometimes they are effective in weight reduction, although most often the weight is put on again when their use is terminated. They are used in the treatment of hyperactive children who showed learning and attention disorders.[5]

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[5] Gerald LeDain, chairman, Interim Report of the Commission of Inquiry into the Non-Medical Use of Drugs (Ottawa: Information Canada, 1970), p. 51.

Amphetamines come in liquid or powdered form, in capsules or tablets. The liquid may be taken intravenously or orally. Benzedrine, dexedrine, and methedrine are the major amphetamines used and differ only in strength. Benzedrine was first synthesized in 1927 and was first used in 1932 as a nasal inhaler decongestant. During World War II it was issued to troops to combat fatigue. It is recommended for depressive states, obesity, alcoholism, narcolepsy, and postencephalitic parkinsonism.[6] Truck drivers and students have been known to use "bennies" to stay awake for long periods of time. Dexedrine is similar to benzedrine, but lesser amounts are needed to achieve the same effect.[7]

Methedrine, known as "speed," is the most potent of the amphetamine type. This drug produces "euphoria, excitability, feelings of power, aggressiveness, and insomnia. Excessive doses can cause talkativeness, pupil dilation, nervousness, hyperexcitability, dryness of the mouth, rapid heart beat, violent actions, or paranoid delusions. The drug is considered dangerous for patients with high blood pressure, irregular heart beat, and various cardiac disorders."[8]

Amphetamine use may precipitate an acute temporary psychosis resulting from sustained wakefulness followed by relapse and exhaustion.

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[6] Lingeman, Drugs from A to Z, p. 22.

[7] Ibid., p. 61.

[8] Ibid., p. 165.

The irregularity created by amphetamine causes disorientation and confusion leading to psychosis.[9]

Of recent major concern is the problem of amphetamine abuse by those known as "speed freaks." Methedrine is injected intravenously, and the user experiences a state of euphoria in addition to the excitability usually experienced. Continuous use of amphetemines may lead to psychic dependence. Overdoses often occur from methedrine use while fewer cases are reported for benzedrine use.[10]

Amphetamines are sometimes known in slang terminology as bennies, dexies, peaches, hearts, copilots, speed, among others.[11]

Cocaine is an alkaloid derivative of the coca leaf of the coca bush which grows predominantly in Bolivia, Peru, and Java. In its pure form, cocaine is a white crystalline powder. Drug users take it for its almost violent stimulant and euphoric effects. The favored modes of ingestion are sniffing and injection.[12]

When a user injects cocaine it is often mixed with heroin, or heroin is subsequently injected in order to reduce the effect the cocaine produces. Cocaine acts upon the central nervous system to produce a euphoric excitement and hallucinatory experience. Up to 10 grams a day of cocaine has been taken at frequent intervals. However, 1.2 grains is thought to be a lethal dose.[13]

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[9] Ibid., p. 6

[10] LeDain, Interim Report, pp. 54, 56.

[11] Smith, Kline & French Laboratories, Drug Abuse: A Manual for Law Enforcement Officers (Philadelphia: SK & F, 1968), p. 53.

[12] Lingeman, Drugs from A to Z, p. 44.

Cocaine does not develop a significant physical tolerance in the body. However, when the euphoric effects of the drug begin to wane, depression sets in. The user is often compelled to ingest more to reproduce the euphoria. Hence, a psychic dependence tends to develop.[14]

When use becomes chronic there is an increasing hyperstimulation accompanied by digestive disorders, nausea, loss of appetite, loss of weight, and paranoid delusions. Prolonged sniffing of cocaine results in the deterioration of the lining of the nose and ultimately the bone cells.[15]

Cocaine is variously known as coke, "C", Cecil, Corine, snow, stardust, to name a few.[16]

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[13] *Ibid*.

[14] *Ibid*.

[15] *Ibid*., p. 45.

[16] SK & F, *Drug Abuse: A Manual*, p. 52.

CENTRAL NERVOUS SYSTEM DEPRESSANTS

Alcohol is a central nervous system depressant although many falsely believe it is a stimulant. It is a great crippler of American society and takes many more lives than marijuana, heroin, or any other drug. Alcohol kills through cirrhosis of the liver and automobile accidents. It often results in the loss of productivity and jobs and torn families.

An individual can build a psychic dependence and a tolerance to alcohol resulting in a physical dependence.[17]

Barbiturates (Luminal, Nembutal, Seconal, Amytal, Tuinal, Miltown, Equanil, Doriden, and Placidyl among others) are commonly sedatives or "downers" and act to depress the central nervous system. In small doses they tend to have a tranquilizing effect, whereas in large doses their depressant action spreads to all parts of the central nervous system causing drowsiness and sleep under normal circumstances. Barbiturates are also useful as anticonvulsants such as in epilepsy, or as analgesics when minor pain prevents sleep. Barbiturates are divided into three classifications--long acting, short to intermediate acting, and very fast acting--depending upon the rate of metabolism by the liver.[18]

Barbiturates are physically addictive. Tolerance to the effects of barbiturates develops, and withdrawal effects occur when the drug is stopped. A strong desire to continue taking the drug in large amounts is still present after a few weeks. Addiction to 50 or more sleeping pills a day has been reported. When the drug is suddenly withdrawn, severe, sometimes fatal withdrawal symptoms develop.[19]

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[17] Lingeman, Drugs from A to Z, p. 74.

[18] Ibid., pp. 15, 16.

People begin to abuse barbiturates when they take excessive amounts to control anxiety. "People under excessive stress, or those who cannot tolerate ordinary stress are vulnerable. A few years ago sedatives were drugs of abuse for adults. Now they are being consumed more and more frequently by teenagers." Persons who take amphetamines might also take barbiturates to neutralize the excitability effect.[20]

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[19] *Ibid*., pp. 17, 18.

[20] A Federal Source Book: *Answers to the Most Frequently Asked Questions About Drug Abuse* (Washington: U.S. Government Printing Office, 1970), p. 20.

PSYCHOTROPICS

Psychotropics (tranquilizers such as Mellaril, Stelazine, Compazine, and Thorazine) are drugs which affect behavior and mood without depressing or stimulating the central nervous system. Characteristically, these drugs have little analgesic or anaesthetic properties. Instead, they alter the way one feels rather than changing physiological functions. Tranquilizers are useful in dealing with psychotic and neurotic symptoms. They are particularly effective for anxiety. Tranquilizers do not necessarily produce sedative, depressant, or hypnotic reactions in themselves, but they do potentiate the effects of the opiates, barbiturates, and alcohol. Disruption of thought processes or motor incoordination are uncommon. Withdrawal is psychic rather than physical.[21]

While physiologic functions are altered only slightly, psychotropics can cause rigidity, tremors, shuffling gait, postural abnormalities, and excessive salivation.[22]

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[21] Brotman and Freedman, Community Mental Health Approach, p. 49.

[22] American Medical Association Council on Drugs, AMA Drug Evaluations (Chicago: American Medical Association, 1971), p. 232.

NATURAL HALLUCINOGENS

Natural hallucinogens are derived from various natural substances. This group of chemicals has the ability to evade and disrupt the normal sensory activity of an individual. Hallucinogens are capable of distorting perception, creating dream images, and hallucinations. Physiologically, these chemicals attack the central nervous system and in turn are capable of producing a wide range of physiological effects. It has been demonstrated that areas such as (1) sections of the brain, (2) smooth muscle organs, and (3) neuron mechanisms are affected. Specifically, drugs such as LSD inhibit the production of a substance known as serotonin which plays a role in the transmission of impulses from one nerve ending to another in the brain. However, this has not been proved conclusively.[23]

These drugs include lysergic acid di-ethylamide (LSD), Cannabis sativa (marijuana), psilocin (from psilocybin mushrooms), and mescaline (from peyote cactus).

The raw chemical properties of these drugs are widely distributed across the world and are often found in naturally growing vegetation. Certain types of mushrooms, cactus, tree bark, flower seeds, fungus, and seaweed can provide the chemicals when synthesized in laboratories. To date, however, there is no legitimate use for these drugs except on a research basis.[24]

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[23] Louise G. Richards, Ph.D; Milton H. Joffe, Ph.D.; and George R. Spratto, Ph.D.; LSD-25: A Factual Account (Washington, D.C.: U.S. Government Printing Office, 1969), pp. 6,7.

Historically, hallucinogenic use was restricted to isolated, primitive societies, and was in most cases associated with religious rites. Certain South and North American Indian groups as well as some Siberian tribes have historically employed hallucinogens. In recent years, however, the spread of hallucinogens has migrated to the metropolitan areas of western countries. In addition, it has been found that hallucinogenic use is no longer barred by age, socioeconomic status, or cultural background. Usage has been found in all levels of American life, differentiated only by reasons for use. Various reasons for use have been reported. Self-awareness, self-mastery, religious experience, and to escape the day to day practices and preoccupations of living, etc. In many cases the user has reviewed the drug as a chemical escape to self-renewal and awareness of the spirit. Less noble reasons for use have been peer pressure, boredom, personality disorders, etc.[25]

Lysergic acid di-ethylamide (LSD) was discovered in 1938 by Albert Hoffmann, a Swiss research chemist. The drug was synthesized from a wheat rust fungus. Ironically, the extraordinary powers of LSD were not discovered until five years later when Dr. Hoffmann accidentally ingested a minute amount of the chemical. Dr. Hoffmann recorded the effects of his experience and thus recorded the birth of the LSD "trip."[26]

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[24] President's Commission on Law Enforcement and Administration of Justice, Narcotics and Drug Abuse (Washington: U.S. Government Printing Office, 1967), p. 26.

[25] Coles, Brenner, Meagher, Drugs and Youth, pp. 65-68.

LSD is an odorless, tasteless white crystalline powder which is soluble in water in its pure form. It is an enormously potent chemical in that a dose can be measured in millionths of a gram, or micrograms. The drug may be obtained in a crystalline form, capsules, or a liquid in ampule doses. It may also be deposited on sugar cubes, crackers, or other foods or dissolved and soaked into paper or fabric. It can be ingested by mouth or injected by needle.[27]

In the last fifteen years, a large volume of materials has been accumulated on LSD. Research projects and street use have provided much of what we know about its effects. In 1966,the drug was brought under the control of the Drug Abuse Control Amendment; and, as a result, research on it has been considerably reduced. Street use, however, has not been reduced and many young people are continuing to fall victim to its effects.[28]

One of the possible dangers of the LSD experience is the "flashback." "A flashback is a recurrence of some of the features of the LSD state, days or months after the last dose." The flashback can occur from physical or psychological stress, or by medications such as antihistamines, or by marijuana. Those individuals who have used LSD report that flashbacks are a rare occurrence. It seems that the frequency of flashbacks is proportional to the use of LSD. Flashbacks, without apparent cause, frequently induce anxiety and fear that one is going mad. Suicide is sometimes the result.[29]

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[26] Ibid., pp. 41-44.

[27] Ibid., p. 45.

[28] Ibid., p. 46.

Another danger is the possibility of chromosomal damage. However, the evidence is inconclusive, and the question remains unsolved.[30]

Marijuana is considered a mild hallucinogen. Although it is chemically different from other hallucinogens, its effects are very similar although much milder.

The active ingredient in marijuana is tetrahydracannabinol (THC). It has been found that THC is retained in the body for eight days. Hence, in the chronic smoker a cumulative effect is seen, with lower doses being required to produce a "high." Very little is really known scientifically about the long-term effects of marijuana usage on the individual. It is reported that there is no known medical use for the drug to date. What research has been done either supports or rejects its potential to cause personality or social harm. No concrete evidence has been obtained in the last few years to support either position totally.

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[29] A Federal Source Book: Answers to the Most Frequently Asked Questions About Drug Abuse (Washington: U.S. Government Printing Office, 1970), p. 13.

[30] Coles, Brenner, Meagher, Drugs and Youth, p. 64.

Psilocin was identified in 1953 by Gordon Wasson in Mexico. The mushrooms containing psilocybin are found mostly in Mexico and are eaten. At the outset, the reaction causes dilation of the pupils, nausea, muscular relaxation, coldness of the limbs, and mood alteration such as hilarity. Later, visions set in of brilliant colors, shapes, geometric patterns, and myriad scenes sometimes perceived as if from a lofty height as well as aural hallucinations.[31]

Mescaline is a substance derived from peyote which is a cactus plant with small spineless heads or buttons barely protruding from the earth. It grows wild in the southwestern part of the country and in Central and South America. Mescaline was known to the Aztecs who considered its hallucinogenic properties to be divine. American Indians learned of its qualities in the latter part of the 19th century, and gradually a religious cult grew irrespective of tribal affiliation. The cult was organized as the Native American Church, and the Indians claim a membership of 200,000.[32]

Mescaline does not induce physical dependence, and there are no withdrawal symptoms when its use is discontinued. Tolerance to mescaline may develop although at a slower rate than LSD. Cross-tolerance also develops with LSD and psilocybin. Cross-tolerance is the occurrence of tolerance to more than one drug which has similar effects.[33]

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[31] Lingeman, Drugs from A to Z, p. 178.

[32] Ibid., pp. 198-199.

[33] Ibid., pp. 158-159.

SYNTHETIC HALLUCINOGENS

Synthetic hallucinogens are laboratory preparations with molecular structures similar to natural hallucinogens. These include dimethyltryptamine (DMT), 4 methyl-2, 5 dimethoxy-α-methyl-phenethylamine (STP), and methylene di-oxy-amphetamine (MDA).

DMT is closely related to psilocybin. Orally it has little effect; however, some claim to have experienced mild, short-lived, dreamlike states. Most often it is deposited on parsley and smoked. Its effects closely resemble those of an LSD trip, but are much milder, usually lasting no more than two hours. It has not yet been clearly established what the dangers of DMT are, but recurring anxiety attacks for one to two weeks afterwards have been reported.[34]

STP was first synthesized by the Dow Chemical Company. It got its name either from the popular motor additive or from Timothy Leary ("serenity, tranquility, and peace"). It is more powerful and longer lasting than LSD or DMT. Its effect may last three to four days as compared to LSD effect of 24 hours. Psychotic reaction to the drug is more intense and more likely. Chlorpromazine, a tranquilizer, has been used to calm an LSD taker who has had a panic psychotic reaction. However, it was found to intensify and worsen adverse reactions to STP. Hence treatment is more complicated with STP.[35]

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[34] Coles, Brenner, Meagher, Drugs and Youth, p. 72.

[35] Lingeman, Drugs from A to Z, pp. 228-229.

MDA appeared in 1969 and is a synthetic usually taken orally. MDA causes moderate euphoria with vivid intensification of visual perception and impairment of depth perception. It has been called the love drug frequently inducing orgasms.[36]

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[36] Coles, Brenner, Meagher, Drugs and Youth, p. 72.

OPIATES

Opium is the milky resin obtained from the seed pods of the opium poppy, Papaver somniferum. It is dried to form a brownish gummy substance. The effects of opium have been known since prehistoric times. The opium smoking habit was introduced in America in 1840 by Chinese immigrants.

Opium was used medically to relieve pain, suppress coughing, act as a sedative, and counter diarrhea. Opium addiction produces withdrawal symptoms comparable in severity to those produced by morphine dependence. Tolerance to opium increases rapidly, and an addict may take up to 20 to 40 grams of the drug a day.[37]

An important aspect of opiate addiction is the probability of an overdose. Overdose occurs from the ingestion of too much opium which acts to depress the central nervous system. The result of an overdose is often coma and death from respiratory depression and cessation of breathing. In addition, the human body has a maximum limit of tolerance to opiates which the addict cannot estimate. Thus it is possible that the addict will reach a level of use which his body will not tolerate, and the result is overdose.[38]

Morphine, a natural alkaloid of opium, was first isolated in 1803 by Serturner. It was first used in this country as an analgesic during the Civil

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[37] David P. Ausubel, Drug Addiction: Physiological, Psychological and Sociological Aspects (New York: Random House, 1968), pp. 16-17.

[38] Lingeman, Drugs from A to Z, p. 191.

War. It is still known today as one of the best pain relievers in medicine.[39]

Physiologically, morphine causes constipation, nausea, sometimes vomiting, constriction of the pupils, heaviness of the limbs, itchiness of the face and nose, sweating, respiratory depression, and other symptoms. The drug's psychological effects include analgesia, impairment of mental and physical performance, reduced sex and hunger drives, and changes in mood. Morphine raises the pain threshold, and it relieves the anxiety and fear associated with pain.[40]

The fascination with morphine lies in its ability to reduce sensitivity to both physical and psychological stimuli and to produce euphoria. This drug dulls anxiety, tension, and fear. The addict, under the influence of morphine, is usually indifferent and lethargic. He is little concerned with his personal situation or personal environment while under the influence.[41]

Physical dependence is caused by tolerance to the drug in which the body tissues retain the drug and incorporate it into tissue function. In addition, other side effects include constipation, constriction of the pupils, and excitation.[42]

When ingestion of morphine is terminated, the intensity of withdrawal symptoms varies with the degree of physical dependence. The withdrawal syndrome sets in about 8-12 hours after the last dose. The peak of withdrawal is reached about 36-72 hours after the last dose, and symptoms may last as long as 5-10 days; but insomnia, muscular cramps, and aches and pains may persist for weeks. "In extreme cases, death may result."[43]

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[39] Ibid., p. 174.

[40] Ausubel, Drug Addiction, p. 23.

[41] Smith, Kline & French, Drug Abuse: Escape to Nowhere, p. 30.

[42] Lingeman, Drugs from A to Z, p. 175.

Heroin is a semisynthetic derivative of morphine which was formulated in 1898 in Germany. When it was found that heroin relieved the withdrawal symptoms of morphine addiction, it was acclaimed a cure for morphine addiction. Twelve years passed before it was discovered that heroin was more devastating than morphine; and, by this time, addicts had learned of its effectiveness. Congress prohibited manufacture of heroin in 1924.[44]

Heroin is two to three times as potent as morphine. In equal doses, the effects of heroin and morphine are very similar. Both cause analgesia, drowsiness, and respiratory depression.[45]

Withdrawal symptoms from heroin are somewhat briefer than morphine, but the overall severity is almost identical to morphine. Heroin produces more euphoria and stimulation, and physical dependence develops more quickly than with morphine.[46]

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[43] Smith, Kline & French, Drug Abuse: Escape, p. 31.

[44] Lingeman, Drugs from A to Z, p. 99.

[45] Ibid.

[46] Ibid., p. 100.

One reason that addicts have found heroin to be their drug of choice is undoubtedly because heroin is only half as bulky as morphine, and therefore more easily concealed.[47]

Heroin, like morphine, acts to depress sex, hunger, and aggression. In the depressed state, the heroin addict is free from strivings, relaxed, and detached.[48]

> "And the heroin addict suffering from some psychic pain due to inner anxiety arising from unrelievable subconscious weak identity palliates this pain by suppressing these drives at their source. Immediately the source of pain is deadened, he experiences euphoria, well-being, detachment from the world, and an almost complete absence of normal known hungers."[49]

Heroin sometimes acts as a sex substitute and supplies a sexual gratification similar to an orgasm in the pit of the stomach. Others go into shock which is powerful enough to be akin to death, followed by an immense relief at being alive. The shock comes from destruction of blood cells and lowering of blood temperatures.[50]

Users usually progress in the habit from sniffing (snorting), to skin popping (subcutaneous injection), to mainlining (intravenous injection). Each mode of ingestion gives the addict a better "kick" than the previous mode.[51]

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[47] Ibid.

[48] Ibid., p. 102.

[49] Ibid.

[50] Ibid.

[51] Ibid., p. 103.

Heroin addiction is an extremely expensive habit. Heroin begins in the hills of Turkey where the resin of the opium poppy is grown legally. It is sold by growers for about $15 a kilo. It is converted to crude morphine in Turkey or Syria. It is then worth $4,000 a kilo. In turn, one kilo of pure heroin provides 50,000 bags of heroin which is cut with milk sugar or quinine. On the streets it retails for $5 a bag. Thus, the heroin which was originally worth $15 is now valued at $250,000.

> "The profit margin is staggering, shared by the Turkish peasants who grow it, the Bedouin and Kurdish smugglers who carry it to Beirut, the Lebanese who refine it, the Corsicans who route it from the Middle East through France to the United States, the importers who control the major American markets, the distributors in Harlem, the pushers scattered around the city, and finally the peddler in the streets, usually the only man in the whole process, once the drug has left the Middle East, who feeds upon heroin himself."[52]

Codeine is an alkaloid of opium which occurs naturally in the juices of the opium poppy. It is usually mixed with other substances for use in cough medicines. It has about one-sixth the analgesic effect of morphine and is used only in combatting minor pain. It can cause constipation and nausea as side effects. Large doses have a paradoxical stimulant effect. Codeine addiction is rare but not unknown. Physical dependence does occur although withdrawal symptoms are much milder than those connected with morphine or heroin dependence. Psychic dependence does often occur since users seek out its euphoric effects. Codeine is sometimes used by heroin addicts trying to withdraw themselves (or when heroin is scarce) and use codeine to alleviate their withdrawal symptoms.[53]

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[52] Dick Schaap, Turned On (New York: Harcourt, Brace & World, 1968), pp. 78-79.

Pantopon is an opium preparation containing all its alkaloids in their natural percentages but with inert gums and resins removed. Pantopon is one-half morphine and is therefore half the strength of an equal volume of morphine. It is sometimes used as a substitute for morphine clinically.[54]

Dilaudid is a morphine derivative and is a much more potent pain reliever, being five to seven times as strong as morphine. There is less nausea, vomiting, and sedation than with morphine. Prolonged use results in physical dependence and withdrawal is as severe as that of morphine.[55]

Numorphan is a morphine derivative which is more potent analgesically than morphine.[56]

Laudanum is an opium preparation first compounded in the 16th century by Paracelsus. It was used medicinally for a number of diseases up through the 19th century. It was sold without prescription and its addictive potential was not understood. As a result, such well-known people as Coleridge, Poe, Moussorgsky, and De Quincey were dependent upon it.[57]

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[53] Lingeman, Drugs from A to Z, p. 46.

[54] *Ibid*., p. 194.

[55] *Ibid*., p. 62.

[56] *Ibid*., p. 187.

[57] *Ibid*., p. 124.

SYNTHETIC OPIATES

Dolophine ("dollies" in addict jargon) is better known as methadone. Originally an analgesic, it is now chiefly used in treatment of morphine and heroin addicts, although a state of euphoria may be obtained when excessive amounts are taken. Its principal usefulness is derived from its ability to blockade the euphoric effect of heroin or morphine.[58]

Methadone may be utilized in two ways; to blockade the euphoric effect of heroin or morphine, or maintain the normal feeling of the heroin/morphine addict to prevent withdrawal. The blockade dosage of 8-120 mg. per day is used for the uninspired addict who wishes to quit heroin, but does not have sufficient motivation. Hence, the blockade dosage destroys the euphoric effect. The maintenance dosage in turn is used with the motivated addict. The effect is to keep the addict from going into withdrawal. The maintenance dosage is 25-40 mg. per day.[59]

Observations have shown that methadone has several therapeutic qualities. Chronic administration of methadone produces few, if any, deleterious effects. When taken orally, it is long lasting (24 hours) as compared to 4-6 hours for heroin. It reduces the craving for heroin which drives many detoxified addicts to resume heroin addiction. It produces a cross-tolerance or blockade to other narcotics, which discourages further usage of black market heroin or other opiates.[60]

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[58] Ibid., p. 161.

[59] William F. Wieland, M.D., "Methadone Maintenance Treatment of Chronic Narcotic Addiction," reprinted from The New Physician, (March 18, 1969), p. 210.

Demerol is a synthetic opiate widely used as an analgesic in childbirth. Because of its accessibility in hospitals, it has become the drug of choice for addicted medical personnel because of the mistaken view that it is not addicting.[61]

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[60] Ibid.

[61] Lingeman, Drugs from A to Z, p. 58.

MARIJUANA

Marijuana (Cannabis sativa) is a durable herbaceous plant growing primarily in arid or semi-arid climates. It grows to a height of 8 to 20 feet. It is dioecious; that is, there are male and female plants. Taller and short-lived, the male plant usually dies soon after its pollen is shed. Until the advent of synthetics, the male plant was cultivated for its hemp fiber used in the making of rope. The female plants are bushier, pollinate, and survive until killed by frost, or their seeds are fully matured.[1]

The principal psychoactive agent in marijuana is Delta 9-tetrahydracannabinol (THC) found in greater abundance in the female plant. Most of this agent is secreted from the flowering tops of the female plant in the form of a clear varnish-like resin called "hashish" which dries into a hard brown cake. THC is also found in other parts of the plant, but the flowers and leaves are the main sources.[2]

Marijuana is not physically addictive. The body does not build a tolerance to the drug although recent evidence shows that THC is retained in the body for up to eight days. Hence, in the chronic smoker a cumulative effect is seen with lower doses being required to produce a state of euphoria.[3] Since there is no tolerance to the drug, there are no withdrawal symptoms. However, marijuana can cause psychological dependence in some smokers.

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[1] Secretary of the Department of Health, Education, and Welfare, Marijuana and Health (Washington, D.C.: U.S. Government Printing Office, 1971), p. 20.

[2] Ibid.

Documentary physiological effects of marijuana inhalation are reflected in an increase in pulse rate which occurs as the body tries to compensate for the deprivation of oxygen. Another physiological effect is conjunctival injection or "red eye." It is hypothesized that minor vascular changes are responsible for this occurrence. Smokers often exhibit the sensations of dry mouth and throat. Appetite is stimulated and is associated with a decrease in blood sugar level. There is a decrease in leg, hand, and finger strength at high dosage levels. The person is uncoordinated when intoxicated and may walk with a staggering gait and slur his speech. Other vital functions, however, such as basal metabolic rate, temperature, respiration rate, and lung vital capacity are generally unchanged.[4]

Psychologically, marijuana smoking brings about a distortion of time sense. The tendency is to overestimate the passage of time as compared to alcohol in which the individual tends to underestimate the passage of time. These determinations were made in the Hollister study where the effect of a 50-60 gm. dose of 95% ethyl alcohol was compared to a 27-37 mg. THC dose of marijuana extract. In addition, Hollister found that marijuana was responsible for alteration of perception which did not occur with alcohol intoxication. Both produced decreased physical activity, euphoria, and sleepiness. Hunger and food consumption were increased by marijuana and decreased by alcohol.[5]

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[3] Testimony of Drs. Harold Kolansky and William T. Moore before the Montgomery County Drug Commission, 11th Session, April 24, 1971, p. 18.

[4] Secretary H.E.W., Marijuana, pp. 9-10.

Set and setting are important aspects in reaching euphoria with marijuana. By "set" we mean the marijuana user's mental outlook. Does he want to take the drug? Is he afraid he will be caught by the police? If the user's mental "set" is positive, he will find it much easier to get "high" than if he is apprehensive. By "setting" we mean his environmental surroundings, the place where he is taking the drug. In a clinical-experimental setting an individual would not get as high as he would in an apartment with the lights dimmed and the phonograph playing.

Acute psychotic episodes occur very infrequently with marijuana use, although more potent hallucinogens such as LSD (160 times as potent as marijuana) may precipitate such attacks.

What is known as the "amotivational syndrome" is the possible consequence of long-term chronic use of marijuana. There is increasing evidence to show that frequent heavy use of marijuana over a long span of time can be correlated with a loss of interest in conventional goals and the development of mental lethargy.[6]

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[5] L. E. Hollister and H. K. Gillespie, "Marijuana, Ethanol, and Dextroamphetamine; Mood and Mental Function Alterations," Archives of General Psychiatry, 23: 199-203, September, 1970 as cited in Secretary H.E.W., Marijuana, p. 107.

Marijuana brings about an impairment of psychomotor performance with a 15-30 mg. oral dose or 4-10 mg. smoked. Simple and familiar tasks requiring rote memory are only minimally affected. However, the more complex and demanding the task, the greater the degree of impairment. Practiced tasks such as knitting would be less affected than tasks such as reading which takes more concentration.

The Melges study demonstrated that marijuana intoxication impairs the ability to (1) "retain events from the preceding few seconds to minutes;" (2) "shift attention appropriately from one focus to another;" (3) "to organize and coordinate serially in time recent information while pursuing a goal directed task." These inabilities were termed "temporal disintegration" by Melges. Difficulty in retaining, coordinating, and indexing information creates memory lapses which leads to disorganized speech and thinking. Temporal disintegration is associated with depersonalization. The person loses his personal identity and causes him to experience himself as strange and unreal during marijuana intoxication.[7]

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[6] Secretary H.E.W., Marijuana, p. 15.

[7] F. T. Melges, J. R. Tinklenberg, L. E. Hollister, and H. K. Gillespie, "Marijuana and Temporal Disintegration," Science, 168 (3935):1118-1120, May 29, 1970 as cited in Secretary H.E.W., Marijuana, p. 101.

Many studies have been undertaken to determine what effect marijuana intoxication has on automobile driving. Crancer's study, which was conducted in an automobile simulator, demonstrated no significant difference between marijuana users and non-marijuana users. However, the same subjects, when intoxicated with alcohol, made significantly greater errors in driving performance.[8]

The McGlothlin study demonstrated that a dose of 15 mg. of THC produced defective driving in terms of "vigilance, divided attention, and psychological refractory time." The same was true of alcohol. Both studies were conducted under simulated conditions, and to resolve the discrepancy, it is probably necessary to devise a more complicated design which more closely reflects the complexities of actual driving.[9]

It has been found that when smoked, marijuana is three times more effective than oral consumption in producing intoxication. Forney and Manno, in addition, found through use of a specially constructed smoking machine that only 50% of the Delta 9-THC present in a marijuana cigarette is delivered to the lungs unchanged. They found that the percentage of delivery did not change by varying the inspiratory volume or the duration of each inhalation.[10] Compared to alcohol, however, this is a great amount. Whereas marijuana is delivered to the lungs and then to the heart and brain, alcohol, on the other hand, travels to the stomach, duodenum, small intestine and large intestine, and is partially detoxified before it goes into the blood stream.[11]

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[8] A. Crancer, J. M. Dille, J. C. Delay, J. E. Wallace, M. D. Haykin, "Simulated Driving Performance," Science, 164:851-854, May 16, 1969, as cited in Secretary H.E.W., Marijuana, p. 103.

[9] W. H. McGlothlin, H. Case, H. E. Moskowitz, "Effects of Marijuana on Driving and Attention," as cited in personal communication to Secretary H.E.W., Marijuana, pp. 103-104.

The La Guardia Report was a study of marijuana under the auspices of Fiorello H. La Guardia, mayor of New York. Completed in 1944, the study was in two parts: a clinical study of the effects of marijuana, and a sociological study of marijuana users in the city.

While the clinical study was conducted at the Goldwater Memorial Hospital in New York, the sociological study was made with the use of prisoners as subjects and were given both natural and synthetic marijuana in oral doses. They were subjected to physiological and mental tests to determine whether it caused physical or mental deterioration. The committee's findings were as follows:

(1) Marijuana accentuates both good and bad traits in the personality by virtue of its property of lowering inhibitions.

(2) Marijuana may precipitate anti-social tendencies which were formerly suppressed.

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[10] J. E. Manno, "Clinical Investigations with Marijuana and Alcohol,"(Submitted to the Faculty of the Graduate School in partial fulfillment of the requirements for the degree of Doctor of Philosophy, Department of Pharmacology and Toxicology, Indiana), as cited in Secretary H.E.W., Marijuana, p. 89.

[11] Testimony of Kolansky and Moore, pp. 24-25.

(3) It does not alter basic personality.

(4) There is no evidence to conclude that continued use of marijuana is a stepping stone to "hard" narcotics.

(5) Prolonged use does not lead to physical, mental, or moral degeneration.[12]

In 1967, the Task Force Report: Narcotics and Drug Abuse conducted by the Federal Government recommended that, "The National Institute of Mental Health should devise and execute a plan of research, to be carried on both on an intramural and extramural basis, covering all aspects of marijuana use."[13]

In 1970, the House Select Committee on Crime studying marijuana made the following recommendations:

(1) The marijuana problem will not be solved by extremists. Rather, this problem calls for sound and logical reasoning.

(2) On the basis of drug users interviewed, the progression hypothesis; that is, marijuana leads to hard drug use, is supported.

(3) The marijuana problem will not be solved by repressive and punitive laws. However, it was observed that maximum sentence for possession or selling are generally not imposed.

(4) A definitive marijuana report was needed.[14]

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[12] Richard R. Lingeman, Drugs from A to Z: A Dictionary (New York: McGraw-Hill, 1969), pp. 122-124.

[13] President's Commission on Law Enforcement and Administration of Justice, Task Force Report: Narcotics and Drug Abuse (Washington, D.C.: U.S. Government Printing Office, 1967), p. 14.

[14] Claude Pepper, chm., Select Committee on Crime, Marijuana (Washington, D.C.: U.S. Government Printing Office, 1970), pp. 107, 114.

In January, 1971, Marijuana and Health was submitted by the Department of Health, Education, and Welfare to Congress. It concluded that for the majority of smokers, marijuana was not harmful. However, for those who were unstable, marijuana could precipitate psychotic episodes. It was determined that not enough is known of marijuana's effects upon long-term chronic smokers. This is due, in part, to the lack of uniform strength of THC content in marijuana.[15]

Proponents and opponents of marijuana have posited many arguments as to whether or not marijuana should be legalized. Some who argue for legalization state that marijuana is not any more detrimental than alcohol and therefore should be legalized. It is hypocritical, they say, to allow alcohol and tobacco to remain legal while marijuana is illegal. Either all three should be illegal, or all three should be legal.[16]

Since we live in a drug-oriented society, we should not castigate those young people who smoke marijuana. Opponents argue that two or three wrongs do not make a right. Just because there are six million alcoholics in the country, does not mean that that number should be added to with youthful people psychically dependent on marijuana.

Marijuana is an intoxicant like alcohol and driving under the influence of marijuana would be extremely dangerous, state opponents of marijuana. According to proponents of marijuana, research studies have not consistently concluded that marijuana and driving are dangerous. People under the influence of marijuana compensate by driving more slowly, braking more quickly, etc.

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[15] Secretary H.E.W., Marijuana, pp. 8, 10, 14.

[16] Montgomery County Drug Commission Hearings, 8th Session, March 24, 1971, p. 7.

The proponents of legalization state that marijuana convictions lead young adults (18 and older) down the path to ruination. The felony conviction denies many young persons the privilege of entering college, graduate school, or professional organizations. A person comes in contact with the criminal element when placed in a correctional institution, an environment which teaches him to be a better criminal. They argue that the punishment does not fit the crime. Many, but not all opponents argue that the marijuana offender knew or should have known what risks he was taking when he participated in an illegal act. Jail will teach the person a lesson, and, hopefully, will rehabilitate him.

Opponents of marijuana argue that chronic Cannabis users are typically "passive, nonproductive, slothful, and totally lacking in ambition." Proponents argue that many of those who take up marijuana are people who are "hungry, sick, hopeless, or defeated, seeking through this drug to soften the impact of an otherwise unbearable reality." They say the research should be conducted to determine if marijuana would be useful as a therapeutic tool in treating depression.[17]

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[17] Lester Grinspoon, "Marihuana," Scientific American, 221:17-25, December, 1969, p. 22.

For those so disposed, Cannabis may lead to psychotic episodes, state opponents of marijuana. The proponents counter with the argument that psychotic episodes are rather rare. In addition, it has been found that the rate of psychoses in the marijuana user population is lower than the rate of functional psychoses in the nonuser population.[18]

Marijuana smokers are often less able to cope with anxiety-producing situations according to opponents. Proponents argue that this conclusion is reached through observation of the marijuana user in the therapeutic setting. Most people reach the therapeutic setting on referral from police or courts. Hence, anyone who has been labeled a criminal and is under surveillance will have greater difficulty making decisions. In addition, it is difficult to estimate the inability of those nonusers who have never been contacted in the population.

Psychic dependence is a possible outcome of marijuana use, state some opponents of marijuana. The physical and psychic functions of the body are in a state of equilibrium under normal circumstances. Use of marijuana as a resultant to "problems," however, does not solve the "problems." It only delays action by the brain. When the problem returns, the user may feel compelled to, once again, "go up." As this cyclical pattern is developed and reinforced, the possibility of psychic dependence becomes probable.[19]

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[18] Ibid., p. 24.

[19] Rev. Peter P. Quinn, "'Pot' Called Harmful to Unstable Youths," Philadelphia Bulletin, November 2, 1970, p. 3.

Proponents argue that based on the overwhelming number who have smoked marijuana, the chances of becoming psychically dependent are rather slim.[20]

They also argue that even if marijuana use leads to psychic dependence, the user's need to be dependent would have been precipitated by those circumstances anyway, and substances other than marijuana would be used. Marijuana, they claim, is the "lesser" of many other evils.

Marijuana robs the adolescent of maturational development during a critical period in his life. Proponents may deny the allegation, but they have no good countering argument.[21]

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[20] Eric Reider, "Youth, Assistant D.A. Disagree on Marijuana," Philadelphia Bulletin, November 11, 1970, p. 3.

[21] Testimony of Kolansky and Moore, p. 19.

LEGISLATION

STATE LAW

The Drug, Device, and Cosmetic Act of 1961 is the controlling drug law in the Commonwealth of Pennsylvania. Since the Drug Commission anticipates that this law will be revised in the near future, a detailed description of the law will not be outlined here.

According to the Act, a "narcotic drug" is opium, coca leaves, marijuana, isonipecaine (a synthetic opiate), or any other drug proclaimed by the Federal Government, after appropriate review, to have "an addiction-forming or addiction-sustaining liability similar to morphine or cocaine." A narcotic drug is also defined as any derivative of the aforementioned substances.

Possession and/or use of a "narcotic drug" is a felony. The penalties as set forth in the Act are as follows:

First offense:	2-5 years and/or $2,000 fine.
Second offense:	5-10 years and/or $5,000 fine.
Third and subsequent offenses:	10-30 years and/or $7,500 fine.

Trafficking (selling, dispensing, giving away) in "narcotic drugs" is a felony. The penalties are as follows:

First offense:	5-10 years and/or $5,000 fine.
Second offense:	10-20 years and/or $10,000 fine.
Third and subsequent offenses:	Life imprisonment and/or $15,000 fine.

The Act defines barbiturates, amphetamines, or any other substances (such as hallucinogens) so designated by the state, after review, as "dangerous drugs."

Possession and/or use of "dangerous drugs" is a misdemeanor. Any other violation of the Act (with the exception of possession, trafficking in "narcotic drugs") is a misdemeanor. The penalties are as follows:

First offense:	0-1 year and/or $5,000 fine.
Second and subsequent offenses:	0-3 years and/or $25,000 fine.

Penalties for trafficking in "dangerous drugs" are not specified in the Act.

State law is enforced by state narcotics agents, County detectives, and local police departments.

FEDERAL LAW

The Harrison Narcotics Act of 1914 was adopted to regulate and tax the use of narcotics including opium, opium derivatives, cocaine, and marijuana. Cocaine and marijuana are legally defined narcotics. Pharmacologically, they are not narcotics since they have none of the chemical properties of opiates. Stiffer penalties for violations of this Act were enacted by the Boggs Amendment of 1951 and the Narcotic Drug Control Act of 1956. The penalties are as follows:

First possession offense:	2-10 years. Probation and parole permitted.
Second possession offense or first selling offense:	Mandatory 5-20 years. No probation or parole permitted.
Third possession or second selling and subsequent offenses:	Mandatory 10-40 years. No probation or parole permitted.
Sale of heroin to person under 18 by one over 18:	10 years to life. No probation or parole; death if jury recommends.

The Narcotic Addict Rehabilitation Act of 1966 defined an addict as "any individual who habitually uses any narcotic drug...so as to endanger the public morals, health, safety, or welfare, or who has been so far addicted to the use of such narcotics as to have lost the power of self-control with reference to his addiction." The federal district court has the discretion to offer to a person, who is determined an addict, commitment to a federal narcotics hospital prior to his trial. If he accepts the 36-month treatment period, the charges are held in abeyance; and if he cooperates during his stay in the facility the charges are dropped. The alternative is to be tried and if found guilty, the penalties would be set in accordance with the controlling law.

The 1966 definition (from the Narcotic Addict Rehabilitation Act) of an "addict" was reiterated in the Comprehensive Drug Abuse Prevention and Control Act of 1970. This Act categorizes drugs into two classifications: "narcotic drugs" and "controlled substances." "Narcotic drugs" include opium, coca leaves, opiates, the derivatives of the above, and any other compound which is chemically identical. "'Controlled substances' means a drug or other substance, or immediate precursor included in Schedules I, II, III, IV, or V . . . ."*

A first offense for "simple possession" of controlled substances is one year imprisonment or one year of probation. If the latter route is taken and the person does not break the conditions of his probation and it is a first offense, then the arrest, indictment, and court records are expunged. Nonpublic records are retained by the Department of Justice. If it is a second offense of simple possession, the penalty is doubled and records are not expunged. The penalties are as follows:

First offense: 1 year prison or probation and/or $5,000 fine.

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* See Drug Schedules Summary at end of this chapter.

Second and subsequent offenses:	2 years imprisonment and/or $10,000 fine.

Penalties for manufacturing, selling, distributing, or possessing with intent to manufacture, etc., "narcotic drugs" under Schedules I and II are as follows:

First offense:	15 years and/or $25,000 fine and a special parole term of 3 years.
Second and subsequent offenses:	30 years and/or $50,000 fine and a special parole term of 6 years.

Penalties for manufacturing, selling, distributing, or possession with intent to manufacture, etc., of a "controlled substance" in Schedules I and II which are not "narcotic drugs;" and controlled substances in Schedule III:

First offense:	5 years maximum and/or $15,000 fine.
Second and subsequent offenses:	10 years maximum and/or $30,000 fine.

Penalties for manufacturing, selling, distributing, or possession with intent to manufacture, etc., of a controlled substance in Schedule IV are as follows:

First offense:	3 years maximum and/or $10,000 fine.
Second offense:	6 years maximum and/or $20,000 fine and additional period of two years parole.

Penalties for manufacturing, selling, distributing, or possession with intent to manufacture, etc., a controlled substance under Schedule V are:

First offense: 1 year maximum and/or $5,000 fine.

Second and subsequent offenses: 2 years maximum and/or $10,000 fine.

Any person who distributes "a small amount of marijuana for no remuneration" is tried for simple possession under this Act.

Special provisions are made for any adult (18 years of age or over) who sells or distributes a "controlled substance" to a minor (under 21 years of age). These are as follows:

First offense: 30 years maximum and/or $50,000 fine and 6 years parole.

Second and subsequent offenses: 45 years maximum and/or $75,000 fine and 9 years parole.

A person is engaged in a "continuing criminal enterprise" when he acts in concert with five or more other persons and he is an organizer, supervisor, or manager of the operation, and when he obtains a substantial income from the operation. Any person who engages in a continuing criminal enterprise forfeits all profits obtained from the enterprise and if guilty:

First offense: 10 years to life imprisonment and $100,000 fine.

Second and subsequent offenses: 20 years to life imprisonment.

Sources

Comprehensive Drug Abuse Prevention and Control Act of 1970. Public Law 91-513. Washington, D.C.: U.S. Government Printing Office, 1970, 61 pp.

Drug, Device, and Cosmetic Act of 1961, The. Public Law 693. Harrisburg: Commonwealth of Pennsylvania, 1961, 30 pp.

Lindesmith, Alfred. *The Addict and the Law*. New York: Vintage Books, 1967, pp. 25-26.

Lingeman, Richard R. *Drugs From A to Z: A Dictionary*. New York: McGraw-Hill, 1969, pp. 91-92.

Narcotic Addict Rehabilitation Act of 1966. Public Law 89-793. Washington, D.C.: U.S. Government Printing Office, 1966, 14 pp.

Drug Schedules Summary*

Schedule I includes opiates, opium derivatives (among others, heroin, morphine), hallucinogenic substances (among others, LSD, DMT, STP, mescaline, peyote, and marijuana).

Schedule II includes substances of vegetable origin or chemical synthesis (opium, opium poppy, coca leaves), opiates (other than those in Schedule I), and stimulants (amphetamines and methamphetamines).

Schedule III includes certain other stimulants, depressants, nalorphine, and certain narcotic drugs when mixed with other chemicals in a pharmaceutical preparation.

Schedule IV includes certain sedatives and tranquilizers.

Schedule V includes preparations containing limited amounts of narcotic drugs in combination with nonnarcotic active medicinal ingredients.

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* The official Drug Schedules will be furnished upon request by the Montgomery County Court House, Norristown, Pa.

MONTGOMERY COUNTY DRUG SERVICES

The Drug Commission has found that there are a number of programs dealing in some way with drug abuse and addiction in the County as of September 1, 1971. Because of the nature of volunteer organizations, it is impossible to make an exact listing of all programs--old programs close and new ones open almost every day. However, this section will give the reader a general idea of what services are available to him.

The drug services have been divided into six program classifications: Treatment (Inpatient and Outpatient), Referral and Information, Clinical Testing, Group Meetings and Lay Counseling, Education and Consultation, and Community Action. In addition, a listing of major out-of-County drug treatment programs is included.

Inpatient treatment programs consist of residential hospital facilities specializing in drug addiction, alcoholism, and psychiatric cases. Outpatient treatment programs include community based treatment services which deal with the problem of addiction and psychiatric problems complicated by drug addiction or abuse. Clinical Testing Centers are state approved laboratories which provide narcotic and dangerous drug testing and analysis for various service groups in the community. Referral and Information Programs are designed primarily for adolescents who may call these programs via a "hotline" and receive advice, understanding, or referral to a more sophisticated helping agency. These programs also provide literature to the public on request.

Group Meetings and Lay Counseling Programs are grass roots community organizations which offer rap sessions, counseling, and referral to persons with problems. Education and Consultation Programs are programs designed to educate the public through speaking engagements and contractual drug education programs. Many of these programs also aid communities in establishing drug programs of their own. Community Action Committees are planning and coordinating organizations.

TREATMENT PROGRAMS

Inpatient

Eagleville Hospital Pre-Inpatient Service
Eagleville Hospital and Rehabilitation Center
Eugenia Memorial Hospital
Norristown State Hospital
Northwestern Mental Health Center

Outpatient

Abington Hospital Mental Health-Mental Retardation Center
Bryn Mawr Hospital Youth Psychotherapy Center
Eagleville Hospital Community Clinic
Lansdale-Ambler Base Service Unit (C.O.P.E. Center)
Lower Merion Mental Health-Mental Retardation Center
Montgomery County Mental Health Clinics, Inc.
Penn Foundation for Mental Health, Inc.
Pottstown Area Mental-Mental Retardation Center
Valley Center, Inc.

REFERRAL AND INFORMATION PROGRAMS

Cheltenham Township Drug Information and Rap Center
Concern
Eagleville Hospital Emergency Telephone Service
Lifeline, Inc.
Tel-E-Help
Upper Moreland Township Youth and Drug Council

CLINICAL TESTING CENTERS

Biomedical Laboratories, Inc.
Medical Diagnostic Center, Inc.
National Medical Services, Inc.

GROUP MEETINGS AND LAY COUNSELING PROGRAMS

Church on the Mall
Crestmont Halfway House Drug Alert Unit
The Helm
Help Line Center, Inc.
Keep It Home, Inc.
Main Line Committee for Parents Drug Education
Main Line Project for Youth
Norristown Halfway House Drug Alert Center
The Shoppe (Perkiomen Valley Youth Center)
The Soul Shack
The Spotafter
Teen Challenge of Norristown
Tesseract
The Wharf

EDUCATION AND CONSULTATION PROGRAMS

Eagleville Hospital Community Services Program
Lankenau Hospital Department of Health Education
Main Line Council on Alcoholism and Other Drug Abuse

COMMUNITY ACTION COMMITTEES

Ambler Drug Abuse Coordinating Council
Central Montgomery County Drug Coalition
Community Organization for Drug Abuse Control (CODAC)
Community Youth Drug Action Council of Eastern Montgomery County (COMAC)
Greater Pottstown Drug Abuse Prevention Program (Insight)
North Penn Human Relations Commission
Upper Dublin Drug Commission

MAJOR DRUG TREATMENT PROGRAMS SURROUNDING MONTGOMERY COUNTY

The Bridge
Daemion House
Gaudenzia House
Help, Inc.
Mantua Halfway House
Narcotic Addiction Rehabilitation Treatment Program
Services to Overcome Drug Abuse Among Teenagers (SODAT)
Teen Challenge of Greater Philadelphia, Inc.
Today, Inc.

Inpatient

Name: Eagleville Hospital Pre-Inpatient Service
Address: Eagleville Road, Eagleville, Pa. 19408
Telephone: 539-6000
Director: Marvin Dichter, Ph.D.

This service is provided to make the most efficient use of hospital facilities at Eagleville, to initiate prospective residents into the program, and to provide service to those who would otherwise be ineligible for lack of space.

The Day Hospital Program provides three types of patient services: those awaiting hospital beds, post-hospital aftercare, and as an alternative to inpatient care. The patient capacity is 20.

The Candidate Program is a half-time work and half-time therapy program. The patients live at Fellowship Farm and are transported to the hospital each day. Fellowship Farm is a camp and conference center located in Fagleysville and is owned by Fellowship House of North Philadelphia. The patient capacity is 14.

Fellowship Farm is used as a residential facility for selected candidates, graduates, day hospital patients, and certain ex-addict staff persons. Day visits and recreational activities are also provided for inpatient residents. The patient capacity is 16. The cost of the above services is $45 per day. It is supported by Medical Assistance, Bureau of Vocational Rehabilitation, Blue Cross, private insurance, private, state and federal funds.

Name: Eagleville Hospital and Rehabilitation Center
Address: Eagleville Road, Eagleville, Pa. 19408
Telephone: 539-6000
Director: Donald J. Ottenberg, M.D.

Eagleville Hospital and Rehabilitation Center is a residential, therapeutic community concerned with the treatment and rehabilitation of alcoholics, drug-dependent persons and drug abusers (with counseling provided for their families). Eagleville also trains professionally related groups, researches the problem of drug dependence, and provides education and outreach to the community.

The inpatient service consists of 126 beds for alcoholic and drug-dependent persons. The only requirement for client entry is that the individual be 16 years of age or older and have a drug or alcohol problem significant enough to interfere with normal functioning or relationships. Excluded are those who are diagnosed psychotic and in need of a psychiatric hospital with more stringent controls. Also excluded are those who have suffered significant forms of brain damage and those with complicating illnesses. A minimum of 24 beds is reserved on a priority basis for Montgomery County citizens. The services consist of psychological evaluation, group therapy, marathon sessions, occupational therapy, recreational therapy, and a full range of medical services. No detoxification is undertaken at

Eagleville. Inpatient care is limited from a 60 to 90 day period at this time. The cost of inpatient service is $45 per day. It is funded by Medical Assistance, Bureau of Vocational Rehabilitation, Blue Cross, private insurance, private, state and federal funds.

Name: Eugenia Memorial Hospital
Address: Thomas Road, Lafayette Hill, Pa. 19444
Telephone: CH 7-4344
Director: Michael O. Grassi, M.D.

Eugenia Memorial Hospital is a 102-bed private psychiatric hospital. It accepts drug abuse cases on referral from affiliated physicians and has 10 beds available for drug cases. It has no formal drug program per se but does provide detoxification, individual psychotherapy, and occupational therapy services. The cost for hospitalization is $40 per day plus special medical costs and doctors' fees. It is supported by hospitalization plans such as Blue Cross and Blue Shield.

Name: Norristown State Hospital
Address: Stanbridge and Sterigere Sts., Norristown, Pa. 19401
Telephone: 275-9700
Director: Michael D. McGuire, M.D.

Norristown State Hospital is a public psychiatric hospital with an alcohol addiction program but no drug program. Some drug addiction cases are taken when complicated by psychosis. The patient capacity for the alcoholic program is 150. The cost is $21.19 per day or $140 per month when the patient is on welfare. It is supported by private and state funds including the Department of Public Welfare.

Name: Northwestern Mental Health Center
Address: 9801 Germantown Ave., Philadelphia, Pa.
Telephone: CH 7-1600
Director: Robert J. Williams

Northwestern Mental Health Center is a private, 100 bed, psychiatric hospital. It has a 20 to 30 day inpatient program for 20 adolescents who are experimenters rather than hard addicts. Detoxification is also provided to major addicts as part of an ongoing adolescent program which includes concepts of therapeutic milieu. The patient capacity is six. The cost of inpatient service is $76.50 per day which includes room and board, occupational therapy, and miscellaneous expenses. It is supported by conventional hospitalization plans.

Outpatient

Name: Abington Hospital Mental Health-Mental Retardation Center
Address: Old York Road, Abington, Pa. 19001
Telephone: 885-4000, Ext. 413
Director: William Carter, M.D.

The Abington Hospital MH-MR Center is a catchment area base service unit of the County MH-MR program. Through its contractual agreement with MH-MR (the following is true of all base service units), it is mandated to provide inpatient services, outpatient services, partial hospitalization services, consultation, education, emergency services, rehabilitation and training services, and interim care services. At the present time Abington provides all of these services to the public sector with the exception of inpatient services. Some inpatient service (24 bed psychiatric unit of the hospital) is provided for self-pay patients. Drug addiction/abuse problems are handled as normal mental health problems. Some outpatient therapy, diagnostic evaluation, and referral service (to Eagleville) is provided. Emergency cases are admitted to the hospital emergency room. Outpatient therapy in the base service unit costs up to $25 per psychiatric hour depending upon the ability to pay. This mental health center is supported by Abington Hospital, hospitalization plans, and the MH-MR program.

Name:	Bryn Mawr Hospital Youth Psychotherapy Center
Address:	Bryn Mawr Ave., Bryn Mawr, Pa. 19010
Telephone:	527-0600, Ext. 248
Director:	Freerk Wouters, M.D. (acting)

The Bryn Mawr Hospital Youth Psychotherapy Center was opened in 1968 as a psychiatric clinic for adolescents. It is the only type of facility of its kind in the County. The center serves all families requesting such service, regardless of income. The center provides outpatient, individual, group, and family therapy for patients 18 years of age and younger including drug cases. The cost varies up to $25 per hour, depending upon the ability to pay. It is supported by the Pediatrics Department of the Bryn Mawr Hospital and the MH-MR program of the County.

Name:	Eagleville Hospital Community Clinic
Address:	6 E. Basin St., Norristown, Pa. 19401
Telephone:	277-5284
Director:	Philip Turner, A.C.S.W.

The Eagleville Hospital Community Clinic is the outpatient clinic for Eagleville Hospital and Rehabilitation Center. It provides post-hospitalization support for patients released from Eagleville Hospital. It also provides services to drug dependent and addicted persons who have never received any form of treatment. These services are provided through the techniques of individual, family, and group therapy. The clinic is open six days a week from 9 a.m. until 10 p.m. Most individual and family counseling is carried on during the day, while most group therapy is done from 6 p.m. to 10 p.m. The average monthly caseload is 600; 65 percent are addicts or abusers. The age range is 14 to 30. Referrals come from many different sources.

The cost of service is up to $25 per hour based on a sliding fee scale. It is supported by Montgomery County Mental Health-Mental Retardation Board (MH-MR), federal funds, and patients' fees.

Name: Lansdale-Ambler Base Service Unit (C.O.P.E. Center)
Address: 46 E. Butler Ave., Ambler, Pa. 19002
Telephone: 643-5522
Director: Roger Smith, M.D. (acting)

The Lansdale-Ambler Base Service Unit provides outpatient therapy, diagnostic evaluations, referrals, and some rap sessions. This unit is the youngest (1970) of the base service units and is still trying to develop its other mandated mental health-mental retardation services. The cost of the service ranges up to $25 per hour on a sliding scale. It is supported by MH-MR and County funds.

Name: Lower Merion Mental Health-Mental Retardation Center
Address: Wynnewood House, 300 E. Lancaster Ave.,
Wynnewood, Pa., 19096
Telephone: 896-8260
Director: Robert Fishman, M.S.W.

Organized in 1969, the Lower Merion MH-MR Center is an adjunct of Resources for Human Development, Inc., a corporation which serves as a funding conduit and stimulates new human services programs. The base service unit provides diagnostic evaluations, referrals, and outpatient therapy. The cost varies up to $25 per hour, depending upon the ability to pay. It is supported by Resources for Human Development, Inc. and the County MH-MR program.

Name: Montgomery County Mental Health Clinics, Inc.
Address: 1100 Powell St., Norristown, Pa. 19401
Telephone: 277-4600
Director: Sidney I. Altman, M.D.

This mental health clinic provides facilities for diagnosis, treatment, and prevention of psychiatric illness on an outpatient basis. It trains professional and para-professional personnel in clinical psychiatric methods, psychiatric social work, and psychology. The clinic educates the community in mental health principles and does research in conjunction with other functions. The clinic has a working agreement with the Eagleville Hospital Community Clinic to provide base service unit treatment to drug-dependent persons. Appropriate cases are in turn referred to the mental health clinic for diagnosis and psychotherapy. Cost of services range up to $25 per hour based on the ability to pay. The program is funded through MH-MR and County sources.

Name: Penn Foundation for Mental Health, Inc.
Address: Lawn Ave., Sellersville, Pa. 18960
Telephone: 257-6551
Director: Norman Loux, M.D.

The Penn Foundation for Mental Health, Inc. is located in Bucks County. The Montgomery County MH-MR program purchases base service unit services. The Penn Foundation provides outpatient services, diagnostic evaluations, day care, marriage counseling, follow-up care, and educational programs. It also has an agreement for inpatient service with Grand View Hospital, Sellersville, Pa. Drug problems are treated as regular mental health problems. The cost of the service is up to $25 per hour, depending upon the ability to pay. It is supported by both MH-MR programs of Montgomery and Bucks Counties.

Name: Pottstown Area Mental-Mental Retardation Center
Address: 1314 High St., Pottstown, Pa. 19464
Telephone: 326-9250
Director: Eugene A. Fee, M.D.

Pottstown Mental Health Center provides outpatient care consisting of individual psychotherapy, group therapy, and family therapy. It also provides aftercare for previously hospitalized patients. Among the specialized outpatient programs is a rap group directed by Dr. Fee. It consists of a core group of 10 and a broader group of 40 people who have drug and communication problems. The age group is from 14 to 20 years, and the cost of the service to the client is up to $25 per hour, depending upon the ability to pay.

Name: Valley Center, Inc.
Address: Fourth & Broad Sts., Lansdale, Pa. 19446
Telephone: 368-2022
Director: Charles Herbert

Valley Center, Inc. is a private psychiatric clinic. Some purchase of service is carried on with the MH-MR program through an informal agreement. There is no drug program per se, but they do make referrals and deal with light drug use in a general program. Overdoses are referred to North Penn Hospital, Lansdale, Pa. The cost is $15 to $20 per psychiatric hour. It is supported by private funds, and when appropriate, MH-MR funds.

REFERRAL AND INFORMATION PROGRAMS

Name: Cheltenham Township Drug Information and Rap Center
Address: Keswick Ave. and Waverly Road, Glenside, Pa. 19038
Telephone: 885-0455
Director: David Opatow

The Cheltenham Township Drug Information and Rap Center is located at the Glenside Free Library and is open every Wednesday night. It disseminates drug literature to the community, has reading materials on drug abuse at the library, and has rap sessions. It also provides referral service. It is supported by the Cheltenham Township Commissioners. The cost of the service is free.

Name: Concern
Address: Lower Merion Senior High School, Montgomery Ave.,
Ardmore, Pa. 19003
Telephone: MI 9-5600
Director: Chris Peters

Concern is a peer referral service located at the Lower Merion High School. The goal of Concern is to try to help those students who are experiencing personal crises caused by the frustrations and pressures of everyday life. Concern will not provide counseling or rap sessions but will guide students to the proper helping agencies. There is no charge for this service.

Name: Eagleville Hospital Emergency Telephone Service
Address: Eagleville Hospital, Eagleville, Pa. 19408
Telephone: 539-6000, Ext. 266
Director: Elsa Legesse

This service provides 24-hour telephone consultation, 24-hour walk-in service and home visitations. It is designed to respond to all age groups and to all types of problems including drugs. There is no cost for this service.

Name: Lifeline, Inc.
Address: P.O. Box 48, Lafayette Hill, Pa. 19444
Telephone: 825-3000
Director: Jerry Litvin

This hotline provides talk-downs for drug users and advice for juveniles experiencing problems. It is open Friday to Sunday from 7 p.m. to 12 a.m. There is no cost for this service.

Name: Tel-E-Help
Address: Abington Hospital Mental Health-Mental Retardation Center,
Old York Road, Abington, Pa. 19001
Telephone: 884-2220
Director: Norman C. Jablon, M.D.

Tel-E-Help is a hotline and referral service sponsored by the Abington Hospital Mental Health Center. It is designed as a link in the community chain of resources to help the juvenile, his parents, or other adults with problems with which they are trying to cope. Cost of the service is free. It is a 24-hour service.

Name: Upper Moreland Township Youth and Drug Council
Address: Building on property of Willow Grove Methodist Church,
York and Cherry Sts., Willow Grove, Pa. 19090
Telephone: OL 9-6864
President: Philip Broadhead

This is a nonprofit organization acting as a referral service. It has volunteers including lawyers, doctors, teachers, and other professional people. It is composed totally of volunteers, and there is no cost for the Council's services.

CLINICAL TESTING CENTERS

Name: Biomedical Laboratories, Inc.
Address: 491 Allendale Road, King of Prussia, Pa. 19406
Telephone: 265-7791
Director: Bernard I. Diamond

Biomedical Laboratories, Inc. is a private, professional testing laboratory which analyzes urine, blood, and stomach contents for drug identification purposes. The service is licensed by the state to analyze narcotics and other dangerous drugs. This service is utilized by police, hospitals, and doctors. The cost is $3.50 upward, depending on the testing required.

Name: Medical Diagnostic Center, Inc.
Address: 1401 DeKalb St., Norristown, Pa. 19401
Telephone: 272-2615
Director: Arthur Sherman, M.D.

The Medical Diagnostic Center is a private clinical laboratory that is licensed by the state to test for narcotics and other dangerous drug substances. It is equipped to analyze urine and blood specimens for narcotics. In addition, it also provides a range of other medical testing services. The cost for drug related testing ranges from $3.50 upward, depending upon the testing required.

Name: National Medical Services, Inc.
Address: 2300 Stratford Ave., Willow Grove, Pa. 19090
Telephone: 657-3565
President: Kenneth A. Hawes

National Medical Services is a private state approved toxicology laboratory providing as part of its services comprehensive drug analysis in urine, blood, body fluids, or tissues. In the community health field services, N.M.S. interacts with law enforcement agencies, coroners, industry, hospitals, and community drug abuse programs. The cost of these services may range from $2 upward, depending upon the extent and type of testing.

GROUP MEETINGS AND LAY COUNSELING PROGRAMS

Name: Church on the Mall
Address: Plymouth Meeting Mall, Plymouth Meeting, Pa. 19462
Telephone: 825-3388
Director: Rev. Allan W. Kinloch

The Church on the Mall is a congregation which meets in the community room at the Plymouth Meeting Mall. This organization seeks to be an outreach instrument in the community and attempts to solve any youth problem including drugs. It gets staff help from Eagleville for this purpose and youth rap sessions are held every Friday.

Name: Crestmont Halfway House Drug Alert Unit
Address: 1555 Rothley Ave., Abington, Pa. 19001 (location)
Box 249, Willow Grove, Pa. 19090 (mailing address)
Telephone: OL 9-2133
Director: Herman E. Young, Jr.

The Crestmont Halfway House is a self-help grass roots program. Rap sessions are held every Wednesday from 7 p.m. until 11 p.m. There is also a telephone service which operates out of a mobile trailer parked on Old York Road. The calls come mostly from youth and may concern any human problem. Group therapy is provided with a client capacity of 30. Speaking engagements are conducted to help educate the community on drug abuse. The Halfway House also sponsors sports teams with recovering addicts as coaches. There is no cost for any of the services. Support is derived from churches, schools, and civic group donations.

Name: The Helm
Address: Ardmore Medical Building, Ardmore, Pa. 19003 (tentative)
Telephone:
Director: Robert Schwartz (acting)

The Helm is a peer counseling and referral service with partial recreation and arts and crafts for youth in Lower Merion. The Helm has joined an ambulance service for handling medical emergencies. It is supported by CODAC. Resources for Human Development, Inc. lends professional staff to the Helm. The cost of the service is free.

Name: Help Line Center, Inc.
Address: 310 S. Broad St., Lansdale, Pa. 19446 (main facility)
627 Walnut St., Lansdale, Pa. 19446 (to be used in the future)
Telephone: 368-4357
Director: Edward Gulian

Help Line Center is a grass roots program serving the North Penn area. It provides seven-night-per-week telephone rap/referral service, walk-in service for rap and/or therapy, and a full drug therapeutic program featuring encounter, supportive counseling, Imaginal Education counseling, social readjustment, parent groups, and drug information. Client entry is determined by an individual's willingness to devote one year's time to the outpatient therapy program. Drug overdoses are referred to North Penn Hospital. The cost of all services is free. Financial support is provided by donations.

Name:	Keep It Home, Inc.
Address:	Suite 301, 319 DeKalb St., Norristown, Pa. 19401
Telephone:	275-6131
Director:	Paul Bono

The goal of Keep It Home is the prevention and intervention of drug abuse by offering alternative activities. They attempt to provide a base for the use of young people's energies, to create self-interest, to provide a sense of togetherness, and neutral help in a social context. The program also provides a recently formed 24-hour phone and referral service known as Homeline.

The job placement service works in conjunction with Opportunities Industrialization Center and the Bureau of Vocational Rehabilitation at Norristown State Hospital. It specializes with people who have records or are on probation or parole. It costs Keep It Home approximately $3 per client. The emergency phone and referral service is for persons requiring help of all types; for example, legal, medical, emergency talk-downs, etc.

The cultural and social entertainment center involves members in such activities as festivals, weekly music, camping trips, workshops, dances, baseball, etc. Most of the cost is carried by Keep It Home. A newspaper, and discussion groups concerning such topics as ecology and drug education are offered through the Discussion and Communication Center. This group is composed primarily of young persons, ages 14 to 25.

Name: Main Line Committee for Parents Drug Education
Address: 1217 Lakemont Road, Villanova, Pa. 19085
Telephone: 527-0469
Directors: Mr. and Mrs. Robert Kress

This is a parent organization created to deal with four areas. The areas are parent education, youth support, information dissemination,and information research. Various educational programs are held with parents concerning drug abuse as well as young people themselves. Physicians and other knowledgeable people are called upon to lecture. General drug information is collected and distributed to various concerned persons. Finally, a systematic attempt is made to evaluate and develop programs to deal with specific drug related needs and problems. It is supported by private funding.

Name: Main Line Project for Youth
Address: 63 W. Lancaster Ave., Ardmore, Pa. 19003
Telephone: 896-8180
Director: Edith Shapin

The Main Line Project for Youth provides individual, family, and group counseling. A major emphasis of the program is the prevention of drug abuse among youth. There is an outreach program utilizing two paraprofessionals to reach youth in order to involve them in rap sessions with a social worker. The cost of these services is free. The project is supported by Jewish Family Service.

Name: Norristown Halfway House Drug Alert Center
Address: 136 W. Penn St., Norristown, Pa. 19401
Telephone: 275-7270-71
Director: Luther A. Mitchell

The Norristown Halfway House provides counseling, talk-downs, and immediate referral help to drug users via a "hotline." It operates to educate grass roots community groups and individuals in the causes, treatment, and prevention of drug abuse. Open rap sessions are held informally whenever there is a need. Closed group sessions of two to eight persons are held twice a week at night. Temporary bed facilities for a maximum of eight persons are provided for up to a 30-day period. The cost for beds is determined by the director and the person's ability to pay. All other services are free. The facility is supported by the Opportunity Board of Montgomery County and donations.

Name: The Shoppe (Perkiomen Valley Youth Center)
Address: Camp Sholom, Route 29, Collegeville, Pa. 19426
Telephone: 489-9865
Director: Rex C. Reichert, Jr.

The Shoppe is a youth center sponsored by the Skip-Perk Jaycees. This center provides a place for young adults to pass time while developing positive social attitudes. Responsibility for operating the Shoppe is given to the young people. In addition to operational matters, special projects are undertaken. Confidential counseling and drug prevention are provided by Eagleville Hospital. Rap groups and community projects to assist local organizations are other activities. The cost of services is free.

Name: The Soul Shack
Address: Ardmore Ave., Ardmore, Pa. 19003
Telephone: 896-8835
Director: Joseph Mason

The Soul Shack is a recreation, counseling, and tutoring program. The recreation program involves basketball, swimming, ping pong, and other activities. The counseling program is staffed by counselors who discuss with youth the usual adolescent problems--school, parents, and drugs. This year, rap sessions, as a part of the counseling program, consist of 10-30 people. Last year the tutoring program involved 32 tutors working with 60 children. The cost of all services is free.

Name: The Spotafter (Huntingdon Valley Community Youth Center)
Address: Red Lion Road & Murray Ave., Huntingdon Valley, Pa. 19006
Telephone: WI 7-9433; WI 7-2616
Director:

The Spotafter is a drop-in center for 9th to 12th graders of the Lower Moreland School District sponsored by the Gloria Dei Evangelical Lutheran Church. It is open from 2:30 p.m. to 5 p.m. on weekdays and Friday nights for dances. There is no formal drug education. It holds rap sessions on Tuesday nights and has various activities in the community.

Name: Teen Challenge of Valley Forge
Address: 1309 S. Trooper Road, Norristown, Pa. 19401
Telephone: 666-6597
Director: Leonard Martin

The director of this program termed this program "an induction center" for those who want to enter the main program in Philadelphia. The program will sponsor "street meetings," will disseminate literature to advertise the program, and will run educational programs in churches, high schools, and colleges. It is supported by the parent organization, Teen Challenge of Philadelphia, and donations.

Name: Tesseract
Address: 315 King St., Pottstown, Pa. 19464 (Pottstown YWCA)
Telephone: 323-1888
Director: Mrs. Barbara Mauger

Tesseract is a drop-in center located in the YWCA which is open Wednesday, Friday, and Saturday nights (closed during the summer). It is operated by four teenagers with two adult advisors for the junior and senior high school population in the Pottstown area. Membership in the organization is $1 per year.

Wednesday night drug rap sessions are held with a community worker from Eagleville Hospital. Friday nights are open to the teenager's discretion. On Saturday nights, live rock bands perform free of charge. The maximum capacity of the facility is 100 persons.

Name: The Wharf
Address: Memorial Baptist Church
2680 Huntingdon Pike, Huntingdon Valley, Pa. 19006
Telephone: WI 7-1880; WI 7-6088
Director: William Powell

The Wharf is a coffee house operated by the Memorial Baptist Church in conjunction with Young Life (a religious young people's group in the community). The Wharf has a strong religious orientation and, in part, serves as a drug prevention program. Entertainment at the coffee house includes folk music and informal discussion. Support is derived from the church and Young Life. There are no charges for services (except refreshments).

EDUCATION AND CONSULTATION PROGRAMS

Name: Eagleville Hospital Community Services Program
Address: 125 Noble St., Norristown, Pa. 19401
Telephone: 277-3715
Director: Joseph Ershun

The purpose of the Community Services Program is to develop contacts with the community in order to act as a referral point to the outpatient clinic, and educate, guide, and advise communities dealing with drug abuse. The program is divided into five units which are School, Criminal Justice, Outreach, Agency Network, and Community Development.

The School Program advises and organizes discussions on methods of preventing drug usage in the Cheltenham, Abington, and Springfield School Districts. The Criminal Justice Program trains members of the criminal justice system in enlightened approaches to drug addiction. The Outreach Program counsels and provides information to professionally oriented groups including civic, health, welfare, and grass roots organizations.

The Agency Network Program is designed to establish relationships with the various County Mental Health Base Service Units. The primary mode of training is through seminars. The Community Development Program educates community groups such as women's clubs, churches, and reaches out to youth in recreation centers for education concerning drugs. The Community Support Program is designed to facilitate adjustment of recovered drug addicts in the community. Cooperative ventures, in drug-free community living, are encouraged. Vocational counseling, self-help projects, and the establishment of cooperative businesses, whenever possible, are part of the program. Research and evaluation is carried on for all discharged drug addicts and alcoholics from a National Institute of Mental Health funding grant.

Name: Lankenau Hospital Department of Health Education
Address: City Line and Lancaster Aves., Philadelphia, Pa. 19151
Telephone: MI 9-1400, Ext. 213
Director: Morris Barrett

This community services program makes realistic drug education available to school districts and community groups in the area. Their philosophy is that effective education is best conducted at the local level by local people with professional guidance. Thus their staff directs the local teachers, then remains in a consultant position to allow the teachers to teach while offering guidance. The cost of this service is $50 per hour per session when in a series of programs; $150 per day; $75 per single session. The program is supported by fees for services purchased. Wissahickon, Lower Merion, Upper Merion, and Souderton School Districts have used their services.

Name: Main Line Council on Alcoholism and Other Drug Abuse
Address: P.O. Box 42, Haverford, Pa. 19041
Telephone: 525-9550
Director: Mrs. Adair Knox Dechant

This is an educational group which sponsors and supports the Main Line Center for Alcoholism. This group meets every other month. Dramatic plays are put on yearly to demonstrate the detrimental effects of drug abuse. It is supported by public contributions.

COMMUNITY ACTION COMMITTEES

Name:	Ambler Drug Abuse Coordinating Council
Address:	Ambler Borough Hall, Butler Ave., Ambler, Pa. 19002
Telephone:	646-1000
Chairman:	George Saurman

This is a community drug prevention group composed of six subcommittees: Drug Education, Law Enforcement, Finance, Treatment-Rehabilitation, Public Relations, and Youth. There are about 50 members. The chairmen of the subcommittees comprise a steering committee which meets with the mayor.

The Council is seeking to expand its role by instituting a Youth Services Bureau to act as a conduit for delivering young people to those who can provide treatment services and recreational activities. The Council is also working with the Lansdale-Ambler MH-MR Base Service Unit and the Visiting Nurses Association to facilitate emergency services in the community.

Name:	Central Montgomery County Drug Coalition
Address:	125 Noble St., Norristown, Pa. 19401
Telephone:	277-3715
President:	Anthony Rieger
Director:	John Kelley (acting)

The Central Montgomery County Drug Coalition is an umbrella organization which will seek to bring constructive changes in community attitudes toward drugs. It will attempt to institute drug education, coordinate various treatment and community resources, identify the need for and help establish new drug services, support existing programs, and solicit public and private funding for these local resources. Its main source of support will be through public and private funding although the exact means is not yet known.

Name: Community Organization for Drug Abuse Control (CODAC)
Address: Lower Merion Township Building, 75 E. Lancaster Ave.,
Ardmore, Pa. 19003
Telephone: 649-4000, Ext. 227
Director: John G. Bennett, Jr.

CODAC is a pilot research and education program funded by the Bureau of Narcotics and Dangerous Drugs which is sponsoring similar projects in Florida, Maryland, Louisiana, Connecticut, Texas, Nebraska, Virginia, North Carolina, and Massachusetts.

Initially this organization planned community seminars to enlist support. It is now writing a proposal which will aid in staffing and planning. CODAC will be an umbrella organization for all presently existing drug related agencies now operating in Lower Merion, Radnor, and Haverford Townships. A "contact house" is planned which will meet the immediate needs of drug abusers with whatever assistance is legally available. It will then refer such persons to other local and state agencies for treatment or rehabilitation as needed. Additional funding has been provided by Lower Merion Township.

Name: Community Youth Drug Action Council of Eastern
Montgomery County (COMAC)
Address: P.O. Box 223, Abington, Pa. 19001
Telephone: WI 7-6565
Director: George W. Meckert, Jr.

COMAC is a drug prevention program sponsored by the York Road Council and Abington Mental Health Center. The purpose of the organization is to coordinate, plan, and implement community services needed to meet youth adjustment problems, and in particular, drug experimentation and addiction. Prevention and detection is an integral part of the program.

The Council will provide education to the school and community including a K-12 drug education,program rap groups, and seminars. Also proposed is the development of a community strategy to educate parents and prevent drug use. It will grant direct services through outreach programs, a referral service, a halfway house, counseling, consultation, and a coffee house. Funds for the project are being collected from various sources.

Name: Greater Pottstown Drug Abuse Prevention Program (Insight)
Address: 900 N. Charlotte St., Pottstown, Pa. 19464
Telephone: 323-0500
Director: Richard E. Horman, Ph.D.

The Pottstown program is a controlled prevention project which will employ a variety of approaches to deal with the drug abuse problem. A research evaluation design will be utilized in order to chart yearly progress and effectiveness of programs. Two target groups will be the subject of prevention attempts: those youth who have never used drugs and those who are just beginning or contemplating use. This service is supported by industry and professional organizations in Pottstown, but state and federal funding sources will be utilized in the future. The cost of the service is free to schools and other organizations

Name: North Penn Human Relations Commission
Address: Lansdale Borough Hall, 421 W. Main St., Lansdale, Pa. 19446 (temporary)
Telephone: 368-1691
Director: William Boehmler, M.D.

This Commission is a recently formed body sponsored by the Borough of Lansdale to deal with drug and other youth related problems. The Commission has attempted to represent a cross-section of the community by electing representatives from every age level. It views its role as one of dealing with all youth problems. At this time, however, it does have a special interest in dealing with drugs and youth alienation from the community. Its future role will be determined by the identified needs of youth in the community.

Name: Upper Dublin Drug Commission
Address: Box 400, Dresher, Pa. 19025
Telephone:
Chairman: Griffith Miller

The Upper Dublin Drug Commission is an organization assigned the task of making preliminary plans for drug abuse services in the Upper Dublin Township area. This Commission works closely with the township government, police department, and school district in planning. It also will disseminate drug information to the community, act as a referral source, and make recommendations. The Commission is sponsored by the Upper Dublin Jaycees. Present sources of income are from private donations.

MAJOR DRUG TREATMENT PROGRAMS
SURROUNDING MONTGOMERY COUNTY

Name: The Bridge
Address: 8400 Pine Road, Philadelphia, Pa. 19111
Telephone: FI 2-5000
Director: Rev. Peter P. Quinn

The Bridge is a drug-free therapeutic adolescent residential program located in the Fox Chase area of Philadelphia. Its main purpose is to provide a treatment program for youngsters who have become drug dependent, and who must relearn in a structured resocialization setting new modes of behavior.

The program, running from six months to two years, requires its patients to progress through three different levels of treatment before they are ready for release. It utilizes various treatment techniques such as group therapy, rap sessions, individual counseling, psychiatric and psychological studies, family therapy and the full range of medical services. It also places a great deal of emphasis on occupational therapy, recreational therapy, and formal academic education. In all phases of the program, the child must become an integrated part of the program. The Bridge has the capacity for 50 children between the ages of 14 and 18 years old.

No direct fees are required by the center for patient care, but parents of residents are asked to contribute what they normally pay to support their child in their home. Other sources of support are through private contribution.

Name: Daemion House
Address: 203 Valley Forge Road, Devon, Pa. 19333
Telephone: 687-5595
Director: John J. Smith

Daemion House is a referral and rap center located in a room behind the St. Luke's Lutheran Church in Devon, Pa. The house, which is operated by volunteers and paid staff members, attempts to help school-age youngsters with their various problems including drugs.

Direct services provided are rap sessions, a hotline referral service, and counseling. In extreme emergencies the program can offer overnight shelter. The house is open from 3 p.m. to midnight, Monday through Thursday; 24 hours a day Friday through Sunday. There is no cost for services provided. The program is supported by contributions and private funds.

Name: Gaudenzia House
Address: 1834 W. Tioga St., Philadelphia, Pa. 19140
Telephone: BA 8-0644
Director: John Ruocco

Gaudenzia is a drug-free therapeutic community treatment program which consists of three different facilities. They are as follows:

Main office and outreach facility:
1834 W. Tioga St., Philadelphia, Pa. 19140

Outreach office:
3137 N. Broad St., Philadelphia, Pa. 19140

Residential treatment center:
1030 S. Concord Road, West Chester, Pa. 19380

Outreach II:
1710 Columbia Ave., Philadelphia, Pa. 19130

The treatment program is an 18 month to two year residential self-help community. It utilizes group confrontation, resocialization learning experiences, authority acceptance, living standards, and the full range of medical and psychological services. The patients are required to make a total commitment to the program and must move through the community free of all drug use.

The program has a present capacity of 50 persons who may be of any age and suffering from any drug problem. The cost of this program is $12.50 per day. All Commonwealth citizens may use this facilty free of charge. Out-of-state residents are charged the daily rate. Other sources of support come from private contributions and the state.

Name: Help, Inc.
Address: 2310 Locust St., Philadelphia, Pa.
Telephone: KI 6-7766-67; KI 6-6925
Medical Clinic, KI 6-8046
Director: Sherri Winter

Help is a 24-hour phone service and drop-in center dealing primarily with the problems of young people. In the words of the director: "We believe in people. We are trying to give people alternatives from which to choose that may help them to solve one of a variety of problems troubling them."

Help's program includes training service, runaway house, individual group and family therapy, abortion counseling, legal staff, medical staff, a medical clinic, psychological staff, veterinarians, food for hungry people, pre-indictment probation program in conjunction with the district attorney's office, trip room, and other services. They are funded by private contributions. There is no charge for services provided by Help.

Name: Mantua Halfway House
Address: 428 N. 38th St., Philadelphia, Pa. 19104
Telephone: EV 7-4160
Director: Kermit B. Gosnell, M.D.

The Mantua Halfway House is an outpatient methadone maintenance program with psychotherapeutic support for heroin addicts in Philadelphia and surrounding areas.

This program was initiated by a group of professional and community members who have attempted to deal with the addict as close as possible to the street habitat where he lives. This form of treatment was undertaken because it could be self-sufficient financially and could also be relevant to the needs of long-term black addicts.

New patients are given a physical examination to check for hepatitis and skin abscesses among other things. A psychological evaluation and laboratory tests follow. The cost of this service is $25 as a registration fee which also buys a one-week supply of medication which is administered daily. Thereafter methadone maintenance costs $10 per week. Also included is group therapy which patients must participate in to get their medication.

Name: Narcotic Addiction Rehabilitation Treatment Program
Address: Philadelphia General Hospital, P.O. Box 8076, Phila., Pa.
Telephone: BA 2-5583
Director: Jacob Schut, M.D.

This narcotic treatment program is a methadone maintenance outpatient treatment center for persons addicted to heroin. In addition to dispensing of methadone the clinic provides counseling, vocational, rehabilitation, drug education, psychological and psychiatric services, and the full range of medical services. All patients 18 years or older who are accepted into the program are carefully screened and followed while in treatment. The methadone is decreased as the patient begins to show social and emotional progress in his daily life until finally his methadone is totally terminated and he is released from the program.

Cost of the treatment is based on the capacity of the patients and their families to pay. Other sources of financial support come from the state and the National Institute of Mental Health.

Name: Services to Overcome Drug Abuse Among Teenagers (SODAT)
Address: 314 Edgmont Ave., Chester, Pa. 19013
332 W. State St., Media, Pa. 19063
Telephone: Chester: 874-2952; Media: 565-4455
Director: Leonard P. Rosen, M.D.

SODAT is an outpatient drug treatment and education program. Its primary objectives are to prevent drug abuse through education, to treat persons suffering from drug abuse, and to negate abuse behavior through the development of appropriate alternatives.

SODAT, which began in 1968, provides an educational program and an outpatient treatment program based on the "Reality-Therapy Philosophy."

SODAT also sponsors an inservice training program. All treatment services offered to individuals are provided free of charge. The program is supported primarily by private contributions, speaking fees, and educational program fees.

Name: Teen Challenge of Greater Philadelphia, Inc.
Address: 1620 N. Broad St., Philadelphia, Pa. 19121
Telephone: CE 2-4636-37
Director: Rev. Robert Bartlett

Teen Challenge is a drug-free program which provides "a home for any disturbed or troubled young person who wants to effect some kind of change in his life through the religious practice and training ever-present in the Teen Challenge program." They believe that drug addiction can be overcome through a personal commitment to Christ.

The client is selected who demonstrates a desire to allow Jesus to effect radical changes in his life. The client must make an honest effort to give "faith therapy" a chance to work.

The inpatient treatment program takes nine months to complete. It is directed by Rev. and Mrs. Bartlett and was begun in June, 1964. The client capacity is 20 single men and 20 single women. The age group is 13-29 years, and the average age is 20. Treatment services offered are free. The program is financed by private contributions and takes no public money.

Name:	Today, Inc.
Address:	Woodbourne and Ellis Road, P.O. Box 317, Newtown, Pa. 18940
Telephone:	968-4713
Director:	John A. Young

This is a 35 bed inpatient facility located in a 20-room farmhouse in Bucks County. The treatment centers around addict-to-addict confrontation. The theme of the program is "Today is the very first day of the rest of your life." Detoxification will be handled at the Doylestown Hospital and the Lower Bucks Hospital. Twelve doctors and three psychiatrists have volunteered their services. The cost for treatment at Today is $23.31 a day. The program is also supported by a $72,000 grant from the Governor's Justice Commission.

A CURRENT DRUG PERSPECTIVE

Introduction

One of the Drug Commission's primary objectives was to determine the number of drug dependent abusers in Montgomery County. It had been reported by various agencies that more and more persons were requesting services for drug dependence, but no comprehensive effort had been made to tabulate County-wide numbers in any given period of time. Thus, the Drug Commission asked medical and legal agencies of the County to report all new drug-identified cases within County borders. The purpose of this effort was to gather factual data for treatment service planning and to further augment the findings of the County drug research study. It is due to the efforts and cooperation of these various agencies that the following figures were reported.

Methodology

In order to acquire the data needed, the Commission requested the assistance of the County hospitals, Mental Health-Mental Retardation facilities, Eagleville Hospital and Rehabilitation Center, District Attorney's Office, Adult and Juvenile Probation Departments, and the Coroner's Office. It was determined that the legal and medical services in the County would be the primary facilities that a drug abuser would come into contact with for help. A statistical data card (see end of this chapter) was prepared and sent to participating facilities. Information requested fell into five categories: sex, age, race, type of drug use, and source of referral. In the reporting, chronic alcohol abuse was classified with other drug abuse substances and referred to in the category "other." The facilities filled in one card for each identified drug user and submitted them to the Drug Commission on a monthly basis.

In some cases, the Drug Commission staff went to the facility and did the necessary research. However, in most cases, the work was done by staff members of the facilities. On occasion, duplications did occur, but every effort was made by the Commission to minimize them in the final reporting. In categories where insufficient data was reported, the information was not included in the final analysis. In every reported case, the anonymity of the individual was maintained by both the participating agency and the Drug Commission staff.

General Discussion

It is the Commission's belief that drug abuse in Montgomery County is increasing and will continue to increase until effective countermeasures are found. The findings also demonstrated that drug treatment services in the County at this time are grossly inadequate and that needs for drug services to date far exceed our capacities to serve.

The following figures are an actual count of persons identified as drug abusers during the last nine months (January 1, 1971 to September 30, 1971):

1. County residents referred to hospital treatment centers for treatment because of drugs since January 1, 1971 279
2. County residents referred to Mental Health-Mental Retardation community mental health centers for treatment because of drugs since January 1, 1971 233
3. County residents referred to Eagleville Hospital Community Clinic for treatment since January 1, 1971 258
4. Male and female adults referred to the District Attorney's Office for alleged violation of the Drug, Device, and Cosmetic Act, 1961; and the Pharmacy Act, 1961 since January 1, 1971 356
5. Male and female adults processed through the Montgomery County Courts for drug abuse and as of January 1, 1971 are on probation or parole . . . 160
6. Male and female juveniles referred to the Juvenile Court of Montgomery County for narcotic and nonnarcotic abuse since January 1, 1971 223
7. Deaths that have occurred in Montgomery County through accidents and suicides that were directly caused by drugs since January 1, 1971 16

The Commission, in reviewing the above information, was firmly convinced that these figures only conservatively reflect the number of cases identified in nine months of investigation. Many cases have gone unreported and many more were identified through resources not participating in this project.

Summary

The preceding data clearly demonstrates that 1,525 County residents have been directly affected by the infection of drug use. In each and every case, these individuals have been thrusted upon the social system with specific needs that have to date either been inadequately served or not dealt with at all. In 16 of these cases, the individuals were identified too late. Though these figures, in and of themselves, may seem small in comparison to the total County population, it must be stressed that they are only a picture of the top of an iceberg in a given period of time and that the total size of the abuser group is still growing and desperately seeking help for their complex problems.

INCIDENCE OF DRUG ABUSE

January 1 to September 30, 1971

HOSPITAL TREATMENT CENTERS

Total:	279
Males:	150
Females:	129

Ages	Cases	Ages	Cases	Ages	Cases
13	3	26	6	41	3
14	15	27	7	42	2
15	10	28	2	43	2
16	26	29	3	45	4
17	29	30	1	46	2
18	41	32	1	47	1
19	19	34	1	49	1
20	19	35	5	50	2
21	19	36	2	51	2
22	12	37	1	56	1
23	7	38	3	58	1
24	3	39	5	92	1
25	9	40	2	Unk.	6

	Type of Use
27	Amphetamines
22	Barbiturates
16	Cannabis (Marijuana)
30	Hallucinogens
60	Heroin
57	Mixed Use
66	Other
1	Solvents

	Source of Referral
1	Church
2	Court
37	Doctor
121	Family
20	Friend
23	Other
24	Police
50	Self Referral
1	Social Agency

HOSPITAL TREATMENT CENTERS

Age and Use Cross Correlation

Age	Amphetamines	Barbiturates	Cannabis	Hallucinogens	Heroin	Mixed Use	Other	Solvents	Age Totals
13						3			3
14		2		2		6	4	1	15
15	1		1	4		2	2		10
16	3		4	4	6	5	4		26
17	4	1	2	5	8	6	3		29
18	2	2	5	2	16	10	4		41
19	5		1	3	4	2	4		19
20	2	1		2	5	5	4		19
21	3	2	3	2	5	2	2		19
22					5	4	3		12
23	1	1				2	3		7
24	1				1		1		3
25				1	2	1	5		9
26	1				2	1	2		6
27	1	3			2		1		7
28					1	1			2
29					1		2		3
30		1							1
32							1		1
34							1		1
35						1	4		5
36				1		1			2
37							1		1
38		2					1		3
39	1	1				2	1		5
40		1					1		2
41						2	1		3
42	1				1				2
43		2							2
45		2					2		4
46							2		2
47							1		1
49		1							1
50						1	1		2
51	1						1		2
56							1		1
58							1		1
92							1		1
Unk.				4	1		1		6
Use Totals	27	22	16	30	60	57	66	1	279

MENTAL HEALTH CENTERS

Total: 233

Males: 145

Females: 88

Ages	Cases	Ages	Cases	Ages	Cases
13	2	25	4	41	1
14	9	26	6	42	4
15	21	27	1	43	1
16	33	29	1	44	2
17	21	30	1	46	2
18	20	31	3	48	1
19	17	32	2	53	1
20	19	33	1	57	1
21	15	34	1	59	1
22	11	35	3	65	1
23	16	36	3	68	1
24	2	39	3	Unk.	2

	Type of Use
15	Amphetamines
9	Barbiturates
34	Cannabis (Marijuana)
12	Hallucinogens
21	Heroin
104	Mixed Use
36	Other
2	Solvents

	Source of Referral
1	Church
12	Court
33	Doctor
51	Family
11	Friend
41	Other
14	Police
45	Self Referral
25	Social Agency

MENTAL HEALTH CENTERS

Age and Use Cross Correlation

Age	Amphetamines	Barbiturates	Cannabis	Hallucinogens	Heroin	Mixed Use	Other	Solvents	Age Totals
13		2							2
14	1	1	1	1		4		1	9
15	1	1	6	2		10		1	21
16	5	2	6	3	1	15	1		33
17	3		3	2	2	11			21
18	2		3	2	4	9			20
19	1		2	1	1	12			17
20	1	1	4		2	10	1		19
21			2	1	3	9			15
22		1			3	7			11
23	1		2		3	9	1		16
24			1		1				2
25			1			2	1		4
26						3	3		6
27					1				1
29							1		1
30							1		1
31			1				2		3
32			1				1		2
33							1		1
34						1			1
35							3		3
36							3		3
39		1					2		3
41							1		1
42						1	3		4
43							1		1
44							2		2
46							2		2
48							1		1
53							1		1
57							1		1
59							1		1
65							1		1
68							1		1
Unk.			1			1			2
Use Totals	15	9	34	12	21	104	36	2	233

EAGLEVILLE HOSPITAL COMMUNITY CLINIC (Outpatient Services Only)

Males (primary patients)	274		
Females (primary patients)	85		
Parents and spouses (relations)	108		
Total patients and relations			467

Primary patients	258		
Previous inpatients	101*		
Total patients		359	
Parents and spouses (relations)		108	
Total patients and relations			467

Ages	Cases
15	12
16-17	39
18-19	63
20-24	104
25-29	37
30-34	17
35-39	22
40-44	26
45-49	12
50+	27

	Type of Use
116	Alcohol
14	Alcohol and Drugs
33	Amphetamines and Other Stimulants
4	Barbiturates
13	Hallucinogens
10	Marijuana
55	Mixed Drugs
112	Opiates
2	Other

	Source of Referral**
13	Base Service Unit
101	Eagleville Hospital (inpatient)
78	Friend
28	Hospital
42	Other Agency
20	Other Individual
45	Physician
30	Probation, Parole, Police
70	Relative
40	Self

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* These are not newly identified cases, as they were previously inpatients.

** Includes patients and relations.

ADULT PROBATION OFFICE

Total: 160 drug cases supervised since January 1, 1971.*

Males: 149

Females: 11

Ages	Cases	Ages	Cases
18	6	26	6
19	18	27	5
20	32	28	3
21	26	29	1
22	11	33	1
23	21	34	1
24	19	38	1
25	7	40	1
		Unk.	1

	Type of Use		Source of Referral
11	Amphetamines	13	County Detectives
4	Barbiturates	103	Local Police
73	Cannabis (Marijuana)	21	Other
7	Hallucinogens	5	Out-of-County Police
30	Heroin	18	State Police
24	Mixed Use		
11	Other		

* Total cases supervised from all years including 1971 total 259.

ADULT PROBATION OFFICE

Age and Use Cross Correlation

Age	Amphetamines	Barbiturates	Cannabis	Hallucinogens	Heroin	Mixed Use	Other	Age Totals
18			3		1	1	1	6
19	1		12	2	3			18
20	1		14	1	9	5	2	32
21	1		10		6	4	5	26
22	1		7	1	1	1		11
23	2	1	8		1	7	2	21
24	2	1	7		5	3	1	19
25		1	3	2		1		7
26	1	1	2	1		1		6
27			3		2			5
28	2		1					3
29			1					1
33						1		1
34			1					1
38					1			1
40					1			1
Unk.			1					1
Use Totals	11	4	73	7	30	24	11	160

JUVENILE PROBATION OFFICE

Total:	223
Males:	176
Females:	47

Ages	Cases
13	6
14	11
15	41
16	80
17	81
18	1
Unk.	3

	Type of Use
12	Amphetamines
19	Barbiturates
120	Cannabis (Marijuana)
11	Hallucinogens
11	Heroin
1	Mixed Use
31	Other
18	Solvents

	Source of Referral
192	Local Police
4	Others
21	Out-of-County Police
6	State Police

JUVENILE PROBATION OFFICE

Age and Use Cross Correlation

Ages	Amphetamines	Barbiturates	Cannabis	Hallucinogens	Heroin	Mixed Use	Other	Solvents	Age Totals
13		2					2	2	6
14		2	5				3	1	11
15		6	20	1	1		9	4	41
16	4	6	50	6	3		5	6	80
17	5	3	45	4	7	1	11	5	81
18	1								1
Unk.	2						1		3
Use Totals	12	19	120	11	11	1	31	18	223

CORONER'S OFFICE

Deaths Due to Drug Overdoses

Total: 16

Males: 4

Females: 12

Ages	Cases
19	1
21	1
22	1
30	1
32	1
33	1
40	2
41	1
43	1
44	1
48	1
49	2
61	1
65	1

Type of Use

1	Amphetamines
3	Barbiturates
3	Heroin
4	Mixed Use
5	Other

DISTRICT ATTORNEY'S OFFICE

January 1, 1970 to December 31, 1970
376* Male and Female Adults Referred

January 1, 1971 to September 30, 1971
387* Male and Female Adults Referred

The above represents the number of persons referred to the District Attorney's Office over the last 21 months. In the 12 months of 1970, 376 male and female adults were arrested for violation of the Drug, Device, and Cosmetic Act (1961, P.L. 693) and/or the Pharmacy Act (1961, P.L. 1700). In the nine months of 1971, 387 male and female adults were arrested once for drug abuse.

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* This number represents only those persons arrested and charged. It does not indicate the number convicted of the violations.

Statistical Data Card

Agency Code ______
Month ____________

MONTGOMERY COUNTY DRUG COMMISSION

Please check or fill in appropriate response for each case

Sex:

☐ Male
☐ Female

Age:

____ Years

Race:

☐ Caucasian
☐ Negro
☐ Other ______

Type of Drug Use:

☐ Heroin
☐ Amphetamine
☐ Barbiturate
☐ Hallucinogen
☐ Cannabis (Marijuana)
☐ Solvents (paint thinner, carbon)
☐ Glue
☐ Mixed Use __________ __________
☐ Other __________________________

Source of Referral

☐ Police
☐ Family
☐ Friend
☐ Court
☐ Social Agency
☐ Doctor
☐ Church
☐ Self Referral
☐ Other _______

A SURVEY OF DRUG USAGE AND ABUSE IN MONTGOMERY COUNTY, PENNSYLVANIA

By

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Morristown, New Jersey

August, 1971

A SURVEY OF DRUG USAGE AND ABUSE IN MONTGOMERY COUNTY, PENNSYLVANIA

INTRODUCTION

There are abundant indications that the drug abuse problem is approaching epidemic proportions throughout the United States. One does not need to have official statistics available to him to be aware of the scope of the problem. The mass media are filled nearly every day with accounts of drug use, arrests, and occasionally, deaths due to, or related to, drug abuse. However, panic and sensation are poor substitutes for accurate data with which to plan and carry out effective prevention, control, and rehabilitation measures.

This problem is, moreover, no longer one that is limited to "ghetto" areas. More and more middle and upper middle class suburban areas are facing this problem in growing proportions and are unable to find effective ways of dealing with it.

A study sponsored by the Pennsylvania Department of Health in 1969 indicated that Pennsylvania has not been immune to this growing problem. The study, which was conducted on students in grades 7 to 12 all over the state further demonstrated the universality of the problem. Of those students in the "high use" category, 70% are from the upper socioeconomic levels. It was further found that living in a rural or a suburban area offered no protection or immunity. In fact, 25% of the high users live in rural areas. Hard data such as this continues to explode the drug abuse myths of the past.

It can be readily seen that although previous studies which analyze national or state-wide drug abuse data can provide useful background information, there is little doubt that we do not know the full extent to which drugs are used or abused by people between the ages of 12 and 25 in Montgomery County. It is also evident that although this study covers the total County, the specific needs of communities within the County differ among themselves. Analysis of the data by school district provides insight into the special uniqueness of each community. In effect, in order to design and implement an effective drug abuse prevention and treatment approach, the specific data by community, sex, age, socioeconomic status and other factors was secured to develop an overall County-based program.

To date, there has never been a comprehensive study in Montgomery County that provides this kind of data. Arrest figures, the number of registered addicts, or even the enumeration of individuals involved in present treatment programs do not provide an accurate measure of the total number of people involved in the use of drugs, the nature of their involvement, or the causal factors related to drug abuse.

Existing or newly created programs have previously been developed on a local community level meeting only those needs perceived by that community. This fragmented approach results in limited services and less than optimum use of funds.

This study was designed to gather the necessary data within Montgomery County to develop a program, or programs which will meet the needs of the County, the communities within the County, and the prevention and control of drug abuse with optimum utilization of funds.

Objectives of the Study

Utilizing a results-oriented approach, our objective was to develop a viable drug abuse prevention and treatment program approach to meet the needs identified from specific survey data.

The sub-objectives necessary to achieve the main objective stated above included:

1. A statistically determined measure of the number of young people (ages 12 to 25) in Montgomery County that are now using drugs.
2. An assessment of the type of drugs being used by Montgomery County youth (LSD, Marijuana, Heroin, etc.).
3. An assessment of the attitudes toward drugs held by Montgomery County youth.
4. The identification of the major causes for the use of drugs by youth in Montgomery County.
5. Identification of those communities in Montgomery County where drug abuse is most serious as reflected by arrest records, survey results, medical referrals, etc.

6. Identification of prominent sources of illegal drugs within the County.

The securing and analysis of this data will allow existing and future treatment, education, and enforcement modalities to begin planning effective programs based upon a common factual body of knowledge pertaining to the population which they serve.

The data should also enable the County to establish priorities such as to provide immediate services to communities where high levels of drug abuse are found. Thus, services pertinent to that community's needs can be given emphasis.

It is with the above objectives in mind that this study was conducted. Needless to say, the study could not have occurred without the almost complete cooperation of County and local officials, Board of Education personnel, and, most important of all, the students of Montgomery County themselves. It was in this spirit of cooperation and a wish to resolve the problem that this study took place.

METHODOLOGY

An investigation of previous studies relating to the causes of the use and abuse of drugs indicates that the examination of single variables and their relationships to drug abuse are subject to significant bias. Depending upon the orientation of the investigator, emphasis has been placed on causative factors ranging from the pressures of society to physiology of the individual to frequency of church attendance. There is some validity to all of these statements about cause. The problem is to subject these many hypotheses to the rigors of scientific and statistical proof while considering the interaction of the many variables at a given time.

The research team approached the development of the test hypotheses by enumerating and defining a set of variables which they believed were related to the incidence of legal and illegal drug use and abuse in Montgomery County. These variables (listed and defined below) were submitted to a task force of approximately sixty school, health, law enforcement, and administrative officials of the County on April 1, 1971. These officials were asked to add to or comment upon the variables listed. Tabulation of the comments clearly indicated that with minor modification the variables as defined could be used to establish the hypotheses to be tested.

Environmental Factors

Demographic. To determine whether the area in which the student lived had a significant relationship to the abuse of drugs. Where did he live? Was the town urban? suburban? rural? Was he happy living there? Did he wish to move?

Family. How significant is the family in the incidence of student drug use and abuse? Data was gathered to determine: With whom did the student live? Are there other siblings? His sibling position? Parents' occupations and working hours? Parents' educational level? Parents' social activities? Family habits relating to smoking, alcohol, pills and other drugs? Family closeness? Religion and attendance at church?

Individual. The normal variation in the personality of individual students has been the subject of educational research for many years. The interaction of individual strengths, concerns, and weaknesses of student respondents and the other drug abuse variables defined is a key area for preventive and rehabilitative program recommendations. Thus, the data sought included: aspirations both occupationally and educationally; self-perception; attitude toward society and its values; ethnicity; society's relevancy to youth; money--How he gets and spends money; after school activities; tolerance and intolerance of drug users and abusers; perception of his peer culture and its influence on him.

School. The educational system is both a source of reward and frustration to the youth contained within it. Many authorities have indicated that the school may be a prime line of defense against the incursion of drug abuse. Others have said that the schools may be a cause of the increase in drug abusers. Thus, the data sought included: achievement in school (grade average), student attitude toward school, teachers, and the relevancy of education.

Drug Culture. It is known that use and abuse of drugs can only take place within a culture that is tolerant of its use. The tolerance can be based upon legal, social, and moral conditions. Thus, the data sought included student knowledge of legal implications of drug abuse, attitudes toward preventive and rehabilitative programs that exist within the County, and normative pressures upon the student.

Specific Data on Use and Abuse of Drugs

Has the respondent used drugs? If so, when? How frequently? Which types?

How long has respondent used drugs?

How difficult is it to obtain drugs? What are the most common sources? Peers? Outside pushers?

Are peers using drugs? To what extent?

What can be done about the problem?

What are the effects of drug use and abuse as seen by the respondent? Medically? Legally? Morally?

Hypotheses Under Test

Each of the variables listed above, in and of themselves, can be studied to provide relevant information. In the opinion of the authors, the interaction and relationship between and among the variables, are the key areas for investigation. Knowing the extent of marijuana use in the County is important, but preventive measures can only come from knowing the causative and associative factors. Thus, a series of null hypotheses were developed which the survey data were designed to test.

Test that there is no significant relationship between youth with poor self-perception and each of the following:

- Age
- Sex
- Religion
- Sibling position
- Family closeness
- Average grade in school
- Use of marijuana
- Use of LSD
- Use of barbiturates
- Use of amphetamines
- Use of heroin

Test that there is no significant relationship between youth who disagree with "middle class values in society" and each of the following:

- Age
- Sex
- Religion
- Sibling position
- Family closeness
- Average grade in school
- Use of marijuana
- Use of LSD
- Use of barbiturates
- Use of amphetamines
- Use of heroin

Test that there is no significant relationship between youth with negative attitudes toward school and each of the following:

- Sex
- Race
- Religion
- Ethnicity
- Father's education
- Mother's education
- Mother's participation in school activities
- Average grade in school
- Grade level in school
- Use of marijuana
- Use of LSD
- Abuse of barbiturates
- Abuse of amphetamines
- Use of heroin

Test that there is no significant relationship between youth affected by peer influence and each of the following:

- Age
- Sex
- Race
- Sibling position
- Number of siblings
- Father's working hours
- Family closeness
- Acceptance of advice
- Activities after school
- Use of drugs at a party
- Use of marijuana
- Use of LSD
- Abuse of barbiturates
- Abuse of amphetamines
- Use of heroin

Test that there is no significant relationship between youth with two parents at home and the following:

- Average grade in school
- Use of alcohol
- Use of marijuana

- Use of LSD
- Abuse of barbiturates
- Abuse of amphetamines
- Use of heroin

Test that there is no significant relationship between the reported availability of specific drugs and the extent of their use in different types of schools.

Test that there is no significant relationship between general student attitude in high use schools as compared to low use schools.

Procedures

General. In order to test the hypotheses established and to gather additional information, the decision was made to proceed with a two phase data gathering procedure. Phase I was a paper and pencil survey to be administered to a sample of the 12 to 25 year old school population in the County. Phase II was to be composed of interviews of randomly selected youth from schools where extremes of data were noted. Areas of high abuse, low abuse, extremely positive school attitudes and similar extremes would be sampled. The intent was to provide additional data not readily gathered in the paper and pencil survey.

Another concurrent phase was added where County preventive and rehabilitative agencies were visited and interviewed. This provides a base for including current efforts within the recommendations evolving from this study.

Survey Instrument. Numerous drug abuse surveys have been conducted during the last several years in the United States and Canada. Most have been concerned with gathering data among school populations. Among our sources for questions to be asked covering the many variables indicated above were:

Study of Attitudes and Actions of Young People,
Narcotic Addiction Control Commission,
State of New York, Fall 1970

1. Areas of concern for young people.
2. How do they generally feel?
3. Attitudes toward school.
4. Possible reasons for taking drugs.
5. Attitudes toward user of drugs.

Student Questionnaire About Drugs,
Alcoholism & Drug Addiction Research Foundations,
London, Ontario, Canada, 1969-1970

1. Family arrangements.
2. Family work habits.
3. Use of drugs and family knowledge of use.
4. Peer use of drugs.
5. Frequency of drug use.
6. Availability of drugs.

The instrument was edited and pre-tested among a population of 30 junior high school and high school students. The instrument was modified to be able to be completed in less than 25 minutes by the average student. This would allow an additional 40% (ten minutes) for the slower reading student to complete the instrument.

It was further found that the questions to be asked of college students would require different answers than those of the other students. Accordingly, a college student instrument was designed which deleted specific questions, broadened the range of answer choices and modified the vocabulary used to be more relevant to this population. Minor modifications were required to allow use of the same answer sheet for the entire sampling population.

Copies of both instruments and the answer sheet are included in the Appendix to this report.

The development of these instruments were heavily dependent on what was considered to be successful instruments from other studies in relevant content areas. For reliability, the Canadian study report indicated, "The part of the instrument that provides the data has been shown to give reliable estimates when matched against usage estimates not based on self-report."

Validity estimates for a study of this type are virtually impossible to obtain. The construct validity of this study approach may include more than purely operational terms and encompass statements which, though anchored in observable data, contain elements that go beyond the data and thus provide a broader, more significant definition than would be provided by a tabulation of data and estimate of what it purports to measure. This study will have to be validated by the accumulation of evidence and the long-term effect of its recommendations.

Sampling. A census of the student population in Montgomery County indicates that:

Students in high school, junior high school, Catholic schools, private schools, Grades 7 to 12	57,000
College students	11,000
Total students	68,000

All schools in the County were invited to participate. A tabulation of those participating is:

Public high schools	1,383
Junior high schools	2,129
Catholic high schools	748
Private schools	942
Colleges	621

A stratified random sample was surveyed within each school. Using the assumption that all students were required to take English, the survey was administered in one English class or its equivalent in each grade 7 to 12 at each school during its regular class period. In schools where there was ability grouping, the selection was made on a random basis.

At the colleges, it was not possible to differentiate subject classes which are required for all students. With the help of the college administration, classes were selected randomly on a time block basis. Thus, each student had an equal chance of being selected. Because of scheduling and other difficulties in some cases, college administration chose to have participation on a voluntary basis with volunteers arriving at a predesignated place and time to complete the instrument. This invalidated some of the college data due to self-selection and nonrandomization.

To assure anonymity, no identification was made on answer sheets other than a school number. After coding and key punching on to data processing cards, the answer sheets were destroyed.

Prior to the administration of the survey in each classroom, students were advised that they did not have to participate if they chose not to. In total, nine chose not to participate.

Implementation. A peer survey team was recruited by the study team. These students were trained in the purposes of the study, the need for preserving anonymity and security procedures. This same group was trained in interviewing techniques for the second phase. Interview sampling was done on a random basis. School administrators selected interviewees on a random basis from enrollment lists. Without prior knowledge, students were sought out in their classes, asked to participate and then interviewed in complete privacy.

Data Analysis. In compiling the data relating to use of the various drugs and then in computation, an arbitrary set of decisions were made to define heavy usage.

Marijuana:	Experimentation could be considered using one to four times. The authors felt that five or more times constituted regular use.

LSD:	Because of the potent effects of LSD, if a person repeated use three or more times, they would be aware of the effects and no longer be experimenting.
Barbiturates and Amphetamines:	Because these drugs are available in many homes, the authors wished to remove the possibility of medicinal use from appearing in the abuse data; thus, the decision to consider heavy use as being eleven or more times.
Heroin:	Since many youth are aware of the addictive properties of heroin, experimentation might result in use one or two times. The authors felt that use three or more times was a firm step toward regular use and possible addiction.

The phi coefficient is a measure of association between two dichotomous variables. In a study of this type where the sample size is quite large, the phi coefficient can be used to indicate which variables are more closely associated to each other. It should be noted that there is significance (.01 level) between two variables when phi is at about .04. However, we chose to drop out phi results below .10 in an attempt to adjust for the large sample. Thus, although a phi of .30 is higher than a phi of .15, it cannot be said that .30 is twice as important as .15. It should be said that although the variables with a phi of .30 are more closely associated than the variables with a phi of .15, they are both significant and both contribute significantly to an explanation of the variance in the original variable.

This report does not show the phi coefficients for each chi-square test. The listing of phi is available to interested researchers upon writing to the Montgomery County Drug Commission.

FINDINGS

MARIJUANA

Incidence in Montgomery County Schools

The use of marijuana and other derivatives of Cannabis sativa in Montgomery County appears to be extensive. Overall, an average of 7.0% of junior high school students, 21.2% of high school students, 26.3% of private school students, and 37.0% of college students have used marijuana five or more times.

The range of use (high and low) for each type of school is:

Marijuana
Used More Than Five Times
Percent of Students Per School
Lowest and Highest Percents

	Low	Average	High
Junior High Schools	0.0%	7.0%	25.0%
High Schools	5.3	21.2	43.4
Private Schools	5.6	26.3	46.5
Colleges	16.9	37.0	70.0

Catholic high schools in the County averaged 15.7% heavy use of marijuana whereas the public high schools averaged at 24.1%. Significantly,* as a total school population, the Catholic high schools had a lower incidence. As will be shown later in this report, when the Catholic students attending other schools are included with the Catholic students in the Catholic high schools, there is no difference in marijuana usage which can be related to religion.

The incidence of marijuana use for each school is shown in the Appendix to this report.

Availability of Marijuana

Respondents were asked to report the availability of marijuana by responding to the following question:

"How difficult is it to obtain marijuana?"

Answer choices

1. My friends give it to me for free.
2. I can buy around school for what it costs my friends.
3. I have to buy it from people I don't know too well.
4. You have to know where to look for it.
5. It's very difficult to buy it.
6. I've never bought or been given marijuana or don't know.

In compiling the data, the easy availability of marijuana was defined as the total of responses to 1, 2, and 3 above. Availability of marijuana data for each school is shown in the Appendix to this report. College data is not reported in that the variation in number of respondents at each college varied greatly and in some cases, respondents were self-selected casting doubt on the data validity.

Use as Related to Availability

In viewing easy availability of marijuana as a feature of the milieu of particular schools rather than of the individual, the question was posed whether the use of marijuana in schools is significantly* related to its easy availability. Separate statistical tests of independence were set up to measure the association between use and availability in the high school-private schools and separately in the junior high schools. A minimum of four high use and four low use schools were selected in each category.

It was found that there is a significant* correlation between the use of marijuana in secondary and private schools and the availability in those schools. However, it was further determined that there is no correlation between the use and extent of availability of marijuana in junior high schools.

Family

1. The use of marijuana is related to the closeness of the family. As the family grows apart, the use of marijuana by the siblings increases.
2. The mothers and fathers of heavy users drink alcohol to excess more frequently than do the parents of nonusers.
3. The parents of heavy users often disapprove of the user's friends.
4. Heavy users will turn for advice only to a "certain brother or sister." (This corresponds quite closely with interview responses which reported users frequently being turned on to marijuana by older brothers and sisters.)

5. Heavy users get a kick out of doing something their parents don't like.
6. Analysis of interview data indicates that nonusers are happier at home than are users.
7. Analysis of interview data indicates that nonusers seek parental approval for their actions more than do heavy users.

School

Heavy users of marijuana--

1. Are less concerned about their grade averages in school.
2. Feel they are not getting a good education.
3. Have poor grade averages (D & F).
4. Feel that classes are not interesting.
5. Don't like school.
6. Feel that teachers don't care about students.

Religion

Heavy users of marijuana--

1. Don't attend church services.
2. Are not concerned about living up to their religious and moral training.
3. Are more proportionately among the Jewish population.

Individual

Heavy users of marijuana--

1. Are afraid of getting involved with drugs. The authors interpret this to mean that they are afraid of getting involved with "harder" drugs.

2. Spend their time after school in three activities:
    a. Studying in dormitories (college students)
    b. Hanging around with other kids
    c. Goofing off
3. Have more money to spend than nonusers.
4. Are afraid of being arrested.
5. Like to do things that shock people.
6. Report that "Life is boring."
7. The extent of marijuana use increases as the youth grow older.

Nonsignificant Variables

In performing this analysis, a number of other variables were tested to determine if a relationship existed between the variable and the use of marijuana. Among those variables where there is no significant* relationship are:

- Sex
- Place of residence
- Race
- Ethnic background
- One or two parents at home
- Youngest, oldest, middle, or only child
- Size of family
- Father's or mother's education
- Father's occupation
- Source of spending money
- Ability to get along with parents
- Pursuit of pleasure

LYSERGIC ACID DI-ETHYLAMIDE (LSD) AND OTHER HALLUCINOGENS

Incidence in Montgomery County Schools

The use of LSD and similar hallucinogens (i.e. mescaline) in Montgomery County is considerable. Overall, an average of 2.2% of junior high school students, 5.6% of high school students, 5.6% of private school students, and 7.6% of college students have used LSD three or more times.

The range of use (high and low) for each type of school is:

Lysergic Di-ethylamide (LSD)
Used More Than Three Times
Percent of Students Per School
Lowest and Highest Percents

	Low	Average	High
Junior High Schools	0.0%	2.2%	8.3%
High Schools	0.0	5.6	13.0
Private Schools	2.8	5.6	25.6
Colleges	1.4	7.6	30.0

Catholic high schools in the County averaged at 3.6% heavy use of LSD whereas the public high schools averaged at 6.7%. Significantly,* as a total school population, the Catholic high schools had a lower incidence. As will be shown later in this report, when the Catholic students attending other schools are included with Catholic students in the Catholic high schools, there is no difference in LSD usage among religions.

The incidence of LSD use for each school is shown in the Appendix to this report.

Availability of LSD

Respondents were asked to report the availability of LSD and similar hallucinogens by responding to the following question:

"Obtaining LSD is:"

Answer choices

1. Very difficult
2. Difficult
3. Not too difficult
4. Pretty easy
5. It's all over the school
6. I don't know

In compiling the data, easy availability of LSD was defined as the total of responses to 3, 4, and 5 above. Availability of LSD data for each school is shown in the Appendix to this report. College data is not reported in that the variation in number of respondents at each college varied greatly and in some cases, respondents were self-selected casting doubt on the data validity.

Use as Related to Availability

As with marijuana an analysis was made comparing the availability of LSD in high use high and private schools as against low use schools, and high use versus low use junior high schools. A minimum of four high use and four low use schools were selected in each category.

There is no significant* correlation between the use of LSD and the extent of its availability among the school population.

The Bureau of Narcotics and Dangerous Drugs of the United States Department of Justice states in its "Fact Sheets,"

> "While millions are exposed to drugs by reason of medical need, relatively few of these people turn to drugs. Even though drugs may be available on street corners...only a small percentage of the individuals exposed join the ranks of the abusers."

Obviously then, the roots of drug abuse in Montgomery County lie not within the supply of the drugs but rather within the social, school, family, religious, and psychological milieu of the individual user.

Family

1. The use of LSD is related to the closeness of the family although not as closely related as in marijuana use. As the family grows apart, the use of LSD by siblings increases.
2. LSD users will not listen to anyone in the family for advice.
3. The parents of LSD users often disapprove of the users' friends.

School

Users of LSD--

1. Maintain poor grade averages (D & F) in school.
2. Don't feel they're getting a good education.
3. Expect to drop out of school.

Religion

Users of LSD--

1. Do not attend religious services.
2. Are not concerned with living up to their religious and moral training.

Individual

Users of LSD--

1. Have more money to spend weekly than nonusers.
2. Spend their time after school hanging around and "goofing off."
3. Are afraid of getting involved with (harder) drugs.
4. The number of youth using LSD increases as we examine older groups.

Nonsignificant Variables

In performing this analysis, a number of other variables were tested to determine if a relationship existed between the variable and the use of LSD. Among those variables where there is no significant* relationship are:

- Sex
- Place of residence
- Desire to move away
- Race
- Ethnicity
- Religion
- One or two parents at home
- Youngest, oldest, middle, or only child
- Size of family

Nonsignificant Variables--contd.

- Mother's or father's occupation
- Parents' consumption of alcohol
- Source of spending money
- Boredom
- Getting along with parents
- Fear of being arrested
- Pursuit of pleasure
- Liking school
- Keeping up with subjects

BARBITURATES

Incidence in Montgomery County Schools

The abuse of barbiturates in the County is at the lowest level among all the drugs except for heroin. It should be noted that barbiturates are physically addictive and represent a different form of hazard than marijuana, LSD, or the amphetamines. The extent of use on the average is: junior high schools, 3.7%; high schools, 4.1%; private schools, 3.7%; and colleges, 6.1%. Heavy use is defined as having taken barbiturates eleven or more times.

The range of use (highest and lowest) for each type of school is:

Barbiturates
Used Eleven or More Times
Percent of Students Per School
Lowest and Highest Percent

	Low	Average	High
Junior high schools	0.0%	3.7%	17.7%
High schools	0.0	4.1	10.7
Private schools	0.0	3.7	7.0
Colleges	0.0	6.1	9.5

It was found that Catholic and public high schools have the same proportion of heavy barbiturate users--4.1%. The incidence of barbiturate use for each school is shown in the Appendix to this report.

Availability

Respondents were asked to report the availability of barbiturates by responding to the following question:

"Obtaining barbiturates is:"

Answer choices:

1. Very difficult
2. Difficult
3. Not too difficult
4. Pretty easy
5. Simple--almost every home has some
6. I don't know

In compiling the data, easy availability of barbiturates was defined as the total of responses to 3, 4, and 5 above. College data is not reported for reasons cited in the previous sections of this report. Availability of barbiturates data for each school is shown in the Appendix to this report.

Use as Related to Availability

As with marijuana and LSD, an analysis was made comparing the availability of barbiturates in high use high and private schools against low use schools, and high use versus low use junior high schools. A minimum of four high use and four low use schools were selected in each category.

There is no significant* correlation between the use of barbiturates and the extent of its availability among the school population.

Family

1. The parents of heavy barbiturate users often disapprove of the user's friends.
2. Heavy barbiturate users won't listen to advice from anyone in the family.
3. The families of heavy users are "not close at all."
4. The parents of heavy users drink to excess more frequently than do the parents of nonusers.
5. Heavy users desire to move away from where they live as soon as possible.
6. Heavy users get a "kick" out of doing things their parents don't like.

School

Heavy barbiturate users--

1. Maintain poor grade averages (D & F) in school.
2. Don't feel they are getting a good education.
3. Don't like school.
4. Feel that classes are not interesting.
5. Expect to drop out of school.

Religion

Heavy barbiturate users--

1. Don't attend church services whereas nonusers attend church

services regularly with their families or by themselves.

2. Are not concerned with living up to their religious or moral training.

Individual

Heavy barbiturate users--

1. Report participating in "other" activities after school. The data does not indicate specific activities other than eliminating staying at home, going out with friends, sports, or clubs, etc.

2. Have more money to spend.

3. Feel life is boring.

4. Are afraid of getting involved with (harder) drugs.

Nonsignificant Variables

In performing this analysis, a number of other variables were tested to determine if a relationship existed between the variable and the use of barbiturates. Among those variables where there is no significant* relationship are:

- Sex
- Age
- Place of residence
- Race
- Ethnicity
- Religion
- One or two parents at home
- Youngest, middle, oldest, or only child
- Size of family
- Mother's or father's occupation
- Mother's or father's education
- Source of spending money
- Concern for future occupation
- Pursuit of pleasure
- Teachers' attitudes

AMPHETAMINES

Incidence in Montgomery County Schools

The abuse of amphetamines, a drug group which can kill and for which a psychological dependence can exist, is occurring in the County as follows: junior high schools, 3.4%; high schools, 5.6%; private schools, 5.5%; and colleges, 11.9%. Heavy use is defined as having taken amphetamines eleven or more times.

The range of use (high and low) for each type of school is:

Amphetamines
Used Eleven or More Times
Percent of Students Per School
Lowest and Highest Percent

	Low	Average	High
Junior high schools	0.0%	3.4%	11.8%
High schools	1.0	5.6	13.9
Private schools	1.4	5.5	18.7
Colleges	7.1	11.9	26.6

It was found that Catholic and public high schools have the same proportion of heavy amphetamine users--5.6%. The incidence of amphetamine use for each school is shown in the Appendix to this report.

Availability

Respondents were asked to report the availability of amphetamines by responding to the folowing question:

"Obtaining amphetamines is:"

Answer choices:

1. Very difficult
2. Difficult
3. Not too difficult
4. Pretty easy
5. Simple
6. I don't know

In compiling the data, easy availability of amphetamines was defined as the total of responses to 3, 4, and 5 above. Availability of amphetamines data for each school is shown in the Appendix to this report. College data is not reported for reasons cited previously.

Use as Related to Availability

An analysis was made comparing the availability of amphetamines in high use high schools and private schools as against low use schools; and high use versus low use junior high schools. A minimum of four high use and four low use schools were selected in each category.

There is no significant* correlation between the use of amphetamines and the extent of its availability among the school population.

Family

Heavy users of amphetamines--

1. Tend to be the only child in the family.

2. Are not part of very close families.
3. Will not listen to anyone in the family except for a certain brother or sister.
4. Have fathers who drink alcohol to excess more often than the fathers of non- or light users.
5. Get a kick out of doing something their parents don't like.
6. Parents often disapprove of their friends.

School

Heavy users of amphetamines--

1. Maintain poor grade averages (D & F) in school.
2. Feel that classes are not interesting.
3. Feel that they are not getting a good education.
4. Feel that there are too many rules and regulations at school.
5. Don't like school.
6. Don't expect to graduate from school.

Religion

Heavy users of amphetamines--

1. Don't attend religious services.
2. Are not concerned about living up to their religious and moral training.

Individual

Heavy users of amphetamines--

1. Have more money to spend than nonusers.

2. Hang around with other kids and "goof-off" after school.
3. Feel life is boring.
4. Like to do things that shock people.
5. Want to move away from where they live as soon as possible.
6. Are afraid of getting involved with (harder) drugs.
7. Are afraid of being arrested.
8. The number of amphetamine users in a given population increases as the group grows older.

Nonsignificant Variables

In performing this analysis, a number of other variables were tested to determine if a relationship existed between the variable and the use of amphetamines. Among those variables where there is no significant* relationship are:

- Sex
- Place of residence
- Race
- Ethnicity
- Religion
- One or two parents at home
- Size of family
- Parents' education
- Father's occupation
- Source of spending money
- Concern about future career
- Pursuit of pleasure
- Teachers' attitudes

HEROIN

Incidence in Montgomery County Schools

Any use of heroin in a County must be considered as significant. In reviewing this data, it should be noted that the evidence is if a student becomes addicted to heroin, his stay in school is brief. Therefore, the data presented here is only about students in school at the time of the study. If anything, the number of youth using heroin in the County is higher than reported here.

An average of 1.8% of high school students, 1.1% of junior high school students, 1.5% of private school students, and 2.1% of college students report use of heroin three or more times.

Heroin
Used Three or More Times
Percent of Students Per School
Lowest and Highest Percent

	Low	Average	High
Junior High Schools	0.0%	1.1%	11.8%
High Schools	0.0	1.8	5.7
Private Schools	0.0	1.5	4.6
Colleges	0.0	2.1	6.6

Both Catholic and public high schools reported the same incidence of heroin use in total--1.8%. The incidence of heroin use in all schools is reported in the Appendix to this report.

Availability

A priori, there was doubt whether respondents would accurately answer questions about availability and sources of heroin. As a result, the authors chose to gather this data from interviews. Unfortunately, the data was not available from interviewing either. During the 187 interviews, the authors encountered one heroin user and one former user. Thus, we cannot conclude anything from the data on availability of heroin in the schools.

Family

Heroin users--

1. Will not listen to anyone in the family for advice.
2. Have parents who drink to excess more than the parents of nonusers.
3. Have parents who disapprove of the user's friends.

School

Heroin users--

1. Maintain a poor grade average (D & F) in school.

Religion

No significant* relationships were detected.

Individual

Heroin users--

1. Have more money to spend.

2. Participate in activities after school other than peer group, school, or family centered activities.

3. Feel that agencies do nothing, talk or call the parents when meeting or dealing with a user.

General

The data indicates that the heroin user is an isolate--other than his identification with a group of other users. The relationships reported above are of sufficiently low order to indicate that the pathology of the heroin user is such that it cannot be determined through the use of group data.

Total Incidence of Abuse

The following data were developed to supplement the basic report on drug use in Montgomery County. Heavy use of the various drugs have been previously defined as:

Marijuana:	five or more times
LSD:	three or more times
Barbiturates:	eleven or more times
Amphetamines:	eleven or more times
Heroin:	three or more times

N = 5,981	Percent Reporting Use as Heavy
Marijuana only	14.3 %
LSD only	7.0
Barbiturates only	7.2
Amphetamines only	6.9
Heroin only	1.7
Marijuana and LSD	1.5
Marijuana and Barbiturates	2.1
Marijuana and Amphetamines	3.2
Marijuana and Heroin	0.7
LSD and Barbiturates	2.1
LSD and Amphetamines	1.9
LSD and Heroin	0.9
Barbiturates and Amphetamines	0.9
Barbiturates and Heroin	0.4
Amphetamines and Heroin	0.4
LSD, Barbiturates, Amphetamines	0.8
LSD, Amphetamines, Heroin	0.06
Barbiturates, Amphetamines, Heroin	0.08
LSD, Barbiturates, Heroin	0.2
LSD, Barbiturates, Amphetamines, Heroin	0.08
Marijuana, LSD, Barbiturates, Amphetamines, Heroin	0.2 *

* The actual number of respondents who indicated heavy use of all five drugs would be 0.4%. A physical check of the answer sheets isolated those responses which indicated false responses were about half. The results were reduced accordingly.

ALCOHOL

At this time the drinking of alcohol (other than to excess) is socially and legally acceptable among adults in the general society. Thus, in examining correlative factors involved with youth drinking in Montgomery County, no data were compiled attempting to identify use and availability among schools or school type. Data was analyzed relevant to associative factors with heavy drinking by young people in school.

The conclusions from this analysis are:

1. Heavier drinking is done by youth with more money to spend.
2. Heavier drinking is reported by those youth who hang around after school with nothing to do.
3. Percentage of youth drinking heavily increases as youth group grows older.
4. The parents of heavy drinkers drink to excess themselves.
5. Drinking occurs most often on the college campus in the dormitories.
6. Heavy drinkers won't turn to anyone in the family for advice.
7. Children from close families drink less.
8. Heavy drinkers maintain poor grade averages (D & F) in school.
9. Catholic youth are the heaviest drinkers.

COMPARISON BETWEEN HIGH AND LOW USE SCHOOLS

It has been previously proven that the use of dangerous drugs in Montgomery County schools is not related to the availability of these drugs (excluding marijuana in the high schools). Thus it is subsumed that there are other significant* variables within the culture of the schools that bear a relationship to the use of drugs.

Accordingly, a series of statistical tests of independence were conducted comparing high and low drug use high schools and private schools. The variables included:

1. Life is boring.
2. I get a kick out of doing something my parents don't like.
3. I have trouble keeping up with my subjects.
4. How would you describe your family?
5. I can't control my life.
6. Where do you live?
7. Degree of concern for living up to my religious and moral training.
8. Do you attend religious services?
9. What do you do most in the evening after school?
10. I like school.
11. Degree of concern for getting along with parents.
12. Teachers don't care about students.

Each of these factors were tested among high and low use schools for LSD, barbiturates, speed, and heroin. The results of this analysis are as follows:

LSD

High LSD use schools--

1. Have more youth from suburban areas.

2. Have more youth who show less concern for living up to their religious and moral training.
3. Have more youth who do not attend church regularly.
4. Have a lack of after school activities to keep youth occupied.
5. Have more youth who don't like school.
6. Have more youth who are less concerned about getting along with parents.

Barbiturates

High barbiturate use schools--

1. Have more youth who report life is boring.
2. Have more youth from urban areas.
3. Have a lack of after school activities to keep youth occupied.

Amphetamines

1. High use amphetamine schools have more youth who stay at home in the evenings after school.

Heroin

High heroin use schools--

1. Have more youth who report life is boring.
2. Have more youth who feel that they can't control their lives.
3. Have more youth who have no concern for getting along with their parents.
4. Have more youth who have no concern for living up to their religious and moral training.

5. Have more youth who don't stay at home after school.

6. Have more youth who don't attend religious services.

7. Have more youth who don't like school.

PEER INFLUENCE

Eleven questions were asked regarding the response of the individual to what he would do if his friends were to do some specific activity. The response choices trichotomized into:

a. Conformance to peer influence.

b. Limited conformance to peer influence.

c. Rejection of peer influence.

Studies of youth have indicated that as the youth enters and proceeds through adolescence, family influence diminishes and peer influence increases. The data confirms this hypothesis. We find, however, that those who reject peer influence completely are very different and the authors find that we are unable to predict their behavior with group data. This group would necessitate individual study and we doubt that they could be group classified.

Specifically, the findings were:

1. Age. High conformers are most influenced to smoke cigarettes and drink alcohol between 14 and 16 and older.

2. Sex. Boys will conform to peer pressure to try all drugs significantly* more than girls.

3. Family closeness. Youth who conform to peer influence to smoke cigarettes or marijuana, drink alcohol and/or use LSD, barbiturates and amphetamines come from families which are not close.

4. Accepting advice. Youth who conform to peer influence to engage in drug abuse, alcohol drinking, and cigarette smoking seek advice from people outside the family.

5. After school activities. Youth who conform to peer influence to engage in drug abuse, alcohol drinking, and cigarette smoking report "hanging around with a group of kids after school."

   Those who are limited conformers report staying at home or participating in activities such as sports, music, or clubs after school.

6. Attendance at parties where drugs are used. Youth who conform to peer influence to engage in drug abuse, alcohol drinking and cigarette smoking go to parties where drugs are used more than do limited conformers.

7. Use of LSD, Barbiturates, Amphetamines, and Heroin. Youth who conform to peer influence on the use of any specific drug are also the heaviest users of the other drugs. Limited conformers more frequently do not use the drugs.

GENERAL DATA ANALYSIS

General Information

Simple tabulation of responses to basic questions in the study results in the following statements:

1. Over 40% of the children in junior high school and high school do not like school. In the public high schools, 57.7% do not like school.
2. Almost 15% of the youth report that life is boring and slightly less feel that they cannot control their lives.
3. More than half of the youth feel that classes are not interesting.
4. Within the high school group, more youth will listen to advice about drugs from ex-users and friends than from anyone else. Fewest will listen to a clergyman, a teacher, a counselor, or law enforcement personnel.

Data Comparisons

1. Boys are more concerned about being arrested.
2. Youth who attend church services are concerned:
    a. About their grades in school.
    b. About getting involved with drugs.
    c. About being arrested.
    d. About living up to their religious and moral training.
3. Youth from families which are not close at all are:
    a. Not happy most of time.
    b. Feel life is boring.
    c. Like to do things to shock people.

d. Feel that they have less fun than most people.

e. Feel that their parents often disapprove of their friends.

f. Do things their parents don't like.

g. Seldom feel close to people.

h. Feel that they can't control their lives.

i. Feel that they don't have a good social life.

j. Are not concerned about their grades in school.

k. Are not concerned about getting along with their parents.

l. Are not concerned about living up to their religious and moral training.

m. Feel that classes are not interesting.

n. Feel that they are not getting a good education.

o. Feel that classes don't have much to do with what's happening.

p. Feel that teachers don't care about students.

q. Feel that there are too many rules and regulations in school.

r. Don't like school.

s. Don't expect to go to college.

4. The mother's participation in school activities is directly related to the child's feeling that he is getting a good education.

5. If a youth maintains a good grade average in school, he feels:

   a. Classes are interesting.

   b. He is getting a good education.

   c. Classes DO have much to do with what's happening.

   d. Teachers care about students.

   e. There aren't too many rules in school.

   f. He likes school.

   g. He expects to graduate from school.

CONCLUSIONS AND INTERPRETATIONS

An analysis of the results of the drug abuse survey is probably best accomplished by pointing out that many variables which have heretofore been regarded by observers and experts as being significantly related to drug abuse have not proven themselves to be significant when under the scrutiny of a scientifically conducted study in Montgomery County. For example, no evidence whatsoever was found in our study to indicate a significant relationship between the abuse of drugs and race, sex, ethnicity, parental education, size of family, ordinate position of sibling in family, and number of parents at home. The general use of drugs seems to cut across class, race, and ethnic groupings.

However, certain other variables have shown themselves to be quite significant. As revealed in this study of Montgomery County youth:

> Drug abuse is directly related to the lack of family closeness or family cohesiveness.
>
> Drug abuse is directly related to the lack of adherence to a formal religious attachment.
>
> Drug abuse is directly related to peer group influence.
>
> Drug abuse is directly related to discontent with school.
>
> Drug abuse is directly related to boredom.
>
> Drug abuse is directly related to influential relationships with siblings and close friends.

There has been considerable belief throughout the United States that the availability of drugs is directly related to its usage. This study indicates that in Montgomery County, the availability of drugs other than marijuana in high schools bears no relationship to the use of drugs.

Tradition and Drugs

A careful interpretation of the massive data obtained in this study indicates a causal relationship between the general breakdown of tradition, attachment to social institutions, and the use of drugs. All the data indicates that disenchantment, boredom, and lack of success in school are associated with drug abuse. The drug user does not like school. More specifically, the user of LSD, barbiturates, and speed expects to drop out of school. The drug user in general is unconcerned about achievement, money, what he is going to do with his life, grades, having friends, getting a job, or having a good time. Institutional breakdown, however, is not confined to school. The drug user does not have a close family; his parents disapprove of his friends; he gets a kick out of doing things his parents don't like; and he wants to move away from wherever he is living at the present time. The influence of the peer group on the drug user is great and seems directly related to the decrease in the influence of his family's values upon him.

Peer groups which are involved in drug abuse have a strong influence upon the individual members and tend to support the individual's use of drugs. The data on peer groups reveals that they are more successful in encouraging boys to use drugs than girls. In addition, the smoking of marijuana by boys at the age of 16 seems to be a direct result of the influence of the peer group coupled with the lack of cohesion of the family.

Additional data from the study confirms that when religious tradition and adherence to church life decreases, drug abuse increases. While there is little difference, for example, between the abuse of drugs among Catholic youth who attend public schools as opposed to non-Catholic youth who attend public schools; nonetheless, children who attend Catholic schools tend to use drugs significantly less than other children.

The data generated by this study also seems to indicate that children who come from families that use "escape" approaches to problem-solving, such as alcoholism, tend to have a higher rate of drug usage than children who come from families where problems are solved in a forthright and realistic fashion.

In essence, the key variables unearthed by this study which are directly related to the abuse of drugs are factors which are related to the breakdown of major influential institutions in Montgomery County. Family, school, church, and peer group all are highly significant in playing the role of either deterring or encouraging the use of drugs.

APPENDICES

It is not possible to determine the total number of youth using all drugs by adding the specific incidence of use for each drug and totaling them. This is because we did not attempt to sort out multiple responses by the same individual.

That is to say that if one individual reports that he has used all drugs extensively, he would appear five times--once in each of the drug categories.

Heavy Use of Drugs and Ready Availability
Percent of Respondents

School	Barbiturates		Amphetamines		Heroin
Number	Use	Avail.	Use	Avail.	Use
High Schools					
505	10.7	28.0	10.6	30.7	2.7
515	7.8	33.0	9.4	32.3	2.4
520	4.3	37.7	2.8	40.5	0.0
525	4.3	39.0	13.0	43.5	2.9
530	3.0	22.7	1.0	22.7	1.0
535	2.1	37.5	8.4	41.6	2.1
540	5.7	39.7	3.8	39.7	5.7
545	1.4	31.8	1.4	36.2	0.0
550	9.8	33.3	13.9	30.5	2.8
555	4.4	44.9	5.6	48.4	0.0
560	6.6	28.8	5.3	32.0	3.9
565	1.6	36.0	8.2	37.7	3.2
570	4.2	31.1	7.0	33.9	1.4
575	3.2	15.8	1.1	24.2	1.1
580	3.9	23.7	2.8	22.1	0.0
585	8.5	34.0	8.5	35.6	3.4
590	0.7	36.2	3.5	32.6	1.4
595	1.6	26.0	4.0	31.7	0.8
600	5.4	37.8	8.2	35.6	1.4
605	1.9	38.9	9.3	46.4	5.6
615	4.1	42.0	10.9	50.1	1.4
620	4.8	36.8	5.0	38.8	3.2
625	1.5	28.3	3.0	35.8	0.0
630	1.4	27.2	4.3	25.7	2.8
635	0.0	23.1	1.5	16.9	0.0
640	1.8	35.5	4.4	36.1	0.6
Private Schools					
2005	5.4	23.4	1.8	21.6	1.8
2010	4.0	23.2	4.0	23.2	1.0
2015	0.0	36.6	2.4	34.1	2.4
2020	2.6	39.5	11.8	48.7	0.0
2025	2.8	19.8	1.4	21.1	0.0
2030	7.0	53.5	18.7	58.2	4.6
2035	5.9	19.6	7.2	23.0	3.3
2040	2.4	30.8	3.7	38.2	1.2
2045	4.8	32.5	4.8	32.5	1.2
2050	1.0	30.1	5.8	33.1	1.0

Heavy Use of Drugs and Ready Availability
Percent of Respondents

School	Barbiturates		Amphetamines		Heroin
Number	Use	Avail.	Use	Avail.	Use
Junior High Schools					
1505	5.5	11.0	4.2	12.5	1.5
1510	2.6	10.3	5.1	9.0	3.9
1515	10.6	18.9	5.2	20.2	0.0
1520	6.4	12.9	6.4	14.2	0.0
1525	2.9	14.5	2.9	15.9	2.9
1530	5.3	21.4	3.6	21.4	3.6
1535	4.4	24.4	2.3	25.6	2.4
1540	1.4	19.2	2.7	19.2	0.0
1545	3.6	28.7	0.0	28.7	0.0
1550	8.1	22.4	4.1	20.5	4.3
1555	7.9	22.6	6.3	16.1	0.0
1560	3.3	20.0	5.0	25.0	0.0
1565	0.0	2.2	0.0	6.5	0.0
1570	0.0	27.0	0.0	27.0	0.0
1575	3.0	16.6	4.5	19.7	0.0
1580	0.0	7.5	0.0	11.3	0.0
1585	3.4	11.6	1.7	8.4	5.0
1590	3.4	10.2	3.4	10.2	0.0
1595	4.6	9.4	2.3	7.0	0.0
1600	6.9	11.1	7.0	11.1	0.0
1605	2.9	8.9	4.4	10.3	5.9
1610	5.6	16.9	5.6	21.2	1.4
1630	3.3	18.1	6.5	19.7	3.2
1635	2.4	10.8	3.6	10.8	0.0
1640	0.0	12.8	1.3	8.9	0.0
1645	17.7	23.5	11.8	23.5	11.8
1650	0.0	9.6	1.6	9.5	0.0
1655	0.0	20.6	0.0	13.7	0.0
1660	4.5	25.4	1.5	21.0	3.0
1665	2.9	11.8	1.5	16.2	0.0
1670	2.8	8.4	2.8	9.8	1.4
1675	1.4	13.6	0.0	15.0	0.0
1680	13.9	28.6	8.3	25.0	8.3

Heavy Use of Drugs and Ready Availability
Percent of Respondents

School	Marijuana		LSD	
Number	Use	Avail.	Use	Avail.
High Schools				
505	28.0	29.3	6.6	24.0
515	17.3	19.7	2.4	20.4
520	10.1	17.3	1.4	27.4
525	37.7	44.9	13.0	33.3
530	10.9	23.8	3.0	23.7
535	27.1	45.9	8.3	43.7
540	43.4	51.0	7.5	34.0
545	20.3	26.0	2.8	29.0
550	33.3	32.0	11.1	30.6
555	29.2	37.1	3.4	37.1
560	20.9	26.2	8.5	23.6
565	18.0	27.8	3.2	29.5
570	19.7	26.8	8.5	32.4
575	5.3	17.9	3.2	12.6
580	5.5	11.1	3.5	18.8
585	27.2	11.9	10.2	25.5
590	14.9	20.6	6.4	26.9
595	15.9	26.2	1.6	25.4
600	24.5	30.0	6.8	28.3
605	28.8	44.5	11.1	38.9
615	39.2	47.3	10.8	43.2
620	22.9	30.5	3.2	32.0
625	37.3	40.3	3.0	22.4
630	12.9	22.8	4.3	24.3
635	9.2	17.2	0.0	15.4
640	14.3	21.1	1.9	24.2
Private Schools				
2005	17.1	28.8	4.5	17.1
2010	32.3	41.4	5.1	27.3
2015	31.7	48.8	7.3	41.5
2020	32.9	42.1	5.3	38.1
2025	5.6	7.0	2.8	15.4
2030	46.5	46.5	25.6	58.2
2035	22.2	21.6	4.0	15.8
2040	25.9	29.6	3.6	32.1
2045	26.5	32.5	7.2	32.5
2050	34.0	34.0	3.9	29.2

Heavy Use of Drugs and Ready Availability
Percent of Respondents

School Number	Marijuana Use	Marijuana Avail.	LSD Use	LSD Avail.
Junior High Schools				
1505	6.7	19.8	5.5	13.9
1510	7.8	11.8	2.6	11.5
1515	11.8	20.0	2.6	19.3
1520	7.5	16.4	0.0	11.1
1525	10.1	18.8	2.9	11.8
1530	4.8	19.3	3.5	24.5
1535	2.1	7.0	0.0	20.0
1540	5.5	18.0	1.4	20.6
1545	10.7	18.5	0.0	24.2
1550	14.2	20.8	7.9	19.8
1555	6.1	9.8	6.1	19.4
1560	10.0	21.6	1.7	18.4
1565	0.0	4.3	0.0	8.7
1570	0.0	12.8	0.0	31.7
1575	4.5	11.8	1.5	9.0
1580	7.5	1.9	0.0	5.7
1585	1.7	10.0	5.1	10.0
1590	1.7	6.8	1.7	5.1
1595	4.6	2.3	2.3	2.3
1600	2.8	11.2	1.4	8.3
1605	7.4	13.2	7.4	8.8
1610	11.3	21.1	1.4	14.1
1630	8.2	19.7	1.6	11.5
1635	2.4	8.4	0.0	9.6
1640	9.0	18.0	0.0	7.7
1645	17.6	23.5	5.9	5.9
1650	2.9	15.9	3.2	7.9
1655	5.7	6.8	1.1	10.2
1660	4.5	10.5	3.0	19.5
1665	3.0	7.4	0.0	5.9
1670	2.8	9.8	0.0	11.2
1675	6.8	14.9	1.4	9.6
1680	25.0	36.8	8.3	22.2

STUDENT QUESTIONNAIRE ABOUT DRUGS

This survey is an attempt to find out the knowledge, attitude and practices of students in Montgomery County with respect to drugs.

Your answer sheet will be anonymous and strictly confidential. Do not sign your name. There is no way your individual answer sheet can ever be identified. The page will be scored and then destroyed.

INSTRUCTIONS

A. You need three things: The Question Booklet
The Answer Sheet
A pencil and eraser.

B. The questions are numbered 1,2,3,4, etc.

The answer choices to each question are also numbered 1,2,3,4, etc.

C. For every question, circle the number identifying your answer on the answer sheet. Choose the ONE right or the best or the closest answer for you.

D. These are the STEPS IN ANSWERING:

1. Read the question CAREFULLY.
2. **Read** all the answer choices. Some are tricky or require thinking.
3. Match the question numbers in the QUESTION BOOKLET and ANSWER SHEET.
4. Match the NUMBER beside your chosen answer with the SAME NUMBER on the ANSWER SHEET.
5. CIRCLE the NUMBER identifying your answer on the ANSWER SHEET.
6. If you make a mistake (such as if you mark the wrong number or mark the wrong question):
   - a. Erase the mistake out completely.
   - b. Circle the right number.

Question 1. Which is your age? Circle the number next to your age on your answer sheet. (For example, if your age is 15 years, circle the 4 next to Question 1.)

1. 12 years or under
2. 13 years
3. 14 years
4. 15 years
5. 16 years
6. 17 years
7. 18 years
8. 19 years
9. 20 years
0. 21 years or older

Question 2. Are you a

1. BOY
2. GIRL

Questions 3 to 13 ask about how you generally feel. If the statement made generally describes how you feel, circle (1) on the answer sheet next to the question number. If the statement does NOT generally describe how you feel, circle (0) on the answer sheet next to the question number.

AGREE (1)
DISAGREE (0)

How do you generally feel?

Question 3. Most of the time I am happy.

Question 4. Life is boring.

Question 5. Sometimes I like to do things that shock people.

Question 6. I have many friends.

Question 7. I have less fun than most people.

Question 8. Things generally work out the way I want them to.

Question 9. My parents often disapprove of my friends.

Question 10. I get a kick out of doing something my parents don't like.

Question 11. I seldom feel close to people.

Question 12. I can't control my life.

Question 13. My social life is satisfying.

Question 14. Of the people you know, how many do you consider to be CLOSE, PERSONAL FRIENDS?

1. One or two
2. Three or four
3. Five or more
4. None

15. Where do you live?

1. In the city or town itself.
2. In the suburbs.
3. In a rural area (farm or away from most other houses).

16. How long have you lived in your present neighborhood?

1. Less than one year.
2. Between one and two years.
3. Between two and five years.
4. Between five and ten years.
5. Over ten years but not all my life.
6. All of my life.

17. If it were up to me only,

1. We would never move away from here.
2. We would move away as soon as possible.
3. It doesn't matter whether we move or not.
4. None of these.

Questions 18 to 31 ask about things that are of concern to most young people today. If the subject covered by the statement CONCERNS YOU A GREAT DEAL, CIRCLE (2) NEXT TO THE QUESTION NUMBER ON THE ANSWER SHEET.

If the subject covered by the statement is OF SOME CONCERN TO YOU but NOT A GREAT DEAL OF CONCERN, CIRCLE (1) NEXT TO THE QUESTION NUMBER ON THE ANSWER SHEET.

If the subject covered by the statement is OF NO CONCERN TO YOU, CIRCLE (0) ON THE ANSWER SHEET NEXT TO THE QUESTION NUMBER.

Great deal of concern to me - 2
Some concern to me - 1
Of no concern to me - 0

18. Deciding what I want to do with my life.

19. Having enough money.

20. Getting good grades.

21. Making friends.

22. Getting along with parents.

23. Getting involved with drugs.

24. Being drafted.

25. Getting a job.

26. Being arrested.

27. Having a good time.

28. Living up to my religious or moral training.

29. Air and water pollution.

30. Unemployment.

31. Racial inequality.

32. I am -

1. Black
2. White
3. Oriental
4. American Indian
5. Puerto Rican
6. None of these

33. What language do your parents speak most of the time?

1. English only
2. Italian, Spanish, Portuguese
3. Jewish, Hebrew
4. German, French, Scandinavian Languages
5. Chinese or Japanese
6. Polish, Czechoslovakian, Hungarian, Romanian, Ukranian, Russian, Greek
7. None of these

34. What is your FAMILY RELIGION? (Religion practiced in your home)

1. Catholic
2. Protestant (Anglican, Presbyterian, United, Baptist, etc.)
3. Jewish
4. Quaker
5. No religion
6. Other
7. I don't know.

35. Do you attend services?

1. Regularly by myself.
2. Regularly with some members of my family.
3. Not at all but belong to a religious group.
4. Not at all and do not belong to a religious group.

36. With whom do you live?

1. Both parents
2. Mother alone (Parents divorced or separated)
3. Father alone (Parents divorced or separated)
4. Mother alone (Father has died)
5. Father alone (Mother has died)
6. Mother and Stepfather
7. Father and Stepmother
8. Other relative
9. None of these

37. Are you ?

1. The only child
2. The oldest child
3. The youngest child
4. Between the oldest and the youngest

38. How many brothers and/or sisters live at home with you?

0. I am the only child or my brothers and sisters don't live at home.
1. One or two
2. Three or four
3. Five or six
4. Seven or more

39. How far did your father go in school?

1. Eighth grade or less
2. Some high school
3. High school graduate
4. Some college
5. College graduate
6. Some graduate study
7. Graduate or professional degree
8. I don't know.

40. How far did your mother go in school?

1. Eighth grade or less
2. Some high school
3. High school graduate
4. Some college
5. College graduate
6. Some graduate study
7. Graduate or professional degree
8. I don't know.

41. What kind of work does your FATHER do?

1. Farmer
2. Semi-skilled (Construction, driving, shipping, general labor)
3. Skilled or Technical (Mechanic, electrician, baker, machine operator)
4. Proprietor (store or small business owner)
5. Clerical or Sales (Bookkeeper, office work, salesman)
6. Professional and Managerial (Doctor, teacher, manager)
7. None of these, Father does not work or has no father

42. When does your father work?

1. Father works all day (day time).
2. Father works shifts or evenings.
3. Father works part-time.
4. None of these - other.
5. My father is not working now.

43. When does your mother work?

    1. Mother works all day (day time).
    2. Mother works shiftw or evenings.
    3. Mother works part-time.
    4. None of these - other.
    5. My mother is not working now.

44. How would you describe your family?

    1. We are very close.
    2. We are somewhat close.
    3. We are not too close.
    4. We are not close at all.

45. To whom would you most likely go in your family for advice or help?

    1. Anyone in the family.
    2. Just my mother and father.
    3. Just my mother.
    4. Just my father.
    5. Any brother or sister.
    6. A certain brother or sister.
    7. Another relative.
    8. No one in the family.

46. Does your father drink alcoholic beverages?

    0 - Never
    1 - Sometimes - not very often
    2 - Often
    3 - No father, or father not living at home

47. Does your father get drunk?

    0 - Never
    1 - Sometimes - not very often
    2 - Often
    3 - No father, or father not living at home

48. Does your father participate in community activities such as Little League, Volunteer Firemen, Lions Club, etc?

    0 - Never
    1 - Sometimes - not very often
    2 - Often
    3 - No father, or father not living at home

49. Does your father take tranquilizers, pills and/or medicines?

    0 - Never
    1 - Sometimes - not very often
    2 - Often
    3 - No father, or father not living at home

50. Does your father smoke (cigarettes, pipes, cigars)?

    0 - Never
    1 - Sometimes - not very often
    2 - Often
    3 - No father, or father not living at home

51. Does your mother drink alcoholic beverages?

0 - Never
1 - Sometimes - not very often
2 - Often
3 - No mother, or mother not living at home

52. Does your mother belong to social clubs?

0 - None
1 - A few (1 or 2)
2 - Many (3 or more)
3 - I don't know - no mother - mother not living at home

53. Does your mother participate in your school activities? (PTA, cake sales, etc.)

0 - Never
1 - Sometimes
2 - Often
3 - No mother, or mother not living at home

54. Does your mother get drunk?

0 - Never
1 - Sometimes - not very often
2 - Often
3 - No mother, or mother not living at home

55. Does your mother take tranquilizers, pills and/or medicines.

0 - Never
1 - Sometimes - not very often
2 - Often
3 - No mother, or mother not living at home

56. How do you get spending money?

1 - Allowance from parents only
2 - Allowance and job
3 - Job only
4 - Other
0 - I don't get any spending money.

57. How much money do you have to spend each WEEK?

1 - 50¢ or less
2 - 51¢ to $2.00
3 - $2.01 to $5.00
4 - $5.01 to $10.00
5 - $10.01 to $20.00
6 - More than $20.00 per week
0 - I don't get any money to spend.

58. What do you most often do in the evenings after school?

1. Stay at home, read, watch TV, etc.
2. Go to a friend's house, go out with a friend
3. Activities (sports, music, clubs)
4. Go out or hang around with a group of kids
5. Other - None of these

Questions 59 to 68 ask about how you generally feel when your friends do something.

59. If my friends smoked cigarettes, I would feel

    1. pleased, want to do the same
    2. it's OK but I don't want to do the same
    3. wish they wouldn't do it
    4. I don't care what they do.

60. If my friends drank alcohol, I would feel

    1. pleased, want to do the same
    2. it's OK but I don't want to do the same
    3. wish they wouldn't do it
    4. I don't care what they do.

61. If my friends smoked marijuana or hashish, I would feel

    1. pleased, want to do the same
    2. it's OK but I don't want to do the same
    3. wish they wouldn't do it
    4. I don't care what they do.

62. If my friends went out on dates, I would feel

    1. pleased, want to do the same
    2. it's OK but I don't want to do the same
    3. wish they wouldn't do it
    4. I don't care what they do.

63. If my friends used LSD, I would feel

    1. pleased, want to do the same
    2. it's OK but I don't want to do the same
    3. wish they wouldn't do it
    4. I don't care what they do.

64. If my friends used Barbiturates (Downers), I would feel
    1. pleased, want to do the same
    2. it's OK but I don't want to do the same
    3. wish they wouldn't do it
    4. I don't care what they do.

65. If my friends used Speed (amphetamines), I would feel

    1. pleased, want to do the same
    2. it's OK but I don't want to do the same
    3. wish they wouldn't do it
    4. I don't care what they do.

66. If my friends used Heroin, I would feel

    1. pleased, want to do the same
    2. it's OK but I don't want to do the same
    3. wish they wouldn't do it
    4. I don't care what they do.

67. If my friends went drag racing, I would feel

    1. pleased, want to do the same
    2. it's OK but I don't want to do the same
    3. wish they wouldn't do it
    4. I don't care what they do.

68. If my friends went "steady," I would feel

    1. pleased, want to do the same
    2. it's OK but I don't want to do the same
    3. wish they wouldn't do it
    4. I don't care what they do.

69. How often have you been at a party where drugs were used?

    1. Never
    2. 1 or 2 times
    3. 3 to 5 times
    4. 6 times or more
    5. I'm not sure if drugs were used.

70. From which ONE of the following sources have you learned the MOST of what you know about drugs?

    1. From church or school
    2. From my family
    3. From the kids I hang around with
    4. From TV, radio, newspapers, magazines
    5. From my own experience with drugs.

Suppose each of the following groups of people gave you advice on the use and abuse of drugs. To whom would you listen?

71. Would you listen to advice from your father or mother? 1. Yes 0. No

72. Police officer, lawyer or judge? 1. Yes 0. No

73. Teacher or school counselor? 1. Yes 0. No

74. Minister, priest or rabbi? 1. Yes 0. No

75. Older brother or sister? 1. Yes 0. No

76. A friend or fellow student? 1. Yes 0. No

77. Someone who has used drugs? 1. Yes 0. No

ON THE BOARD IN FRONT OF THE ROOM IS A NUMBER IDENTIFYING THIS SCHOOL. PLEASE WRITE THAT NUMBER ON YOUR ANSWER SHEET AT 78, 79 and 80.

Here are some statements about your possible feelings about school. For each statement that AGREES with how you feel, circle the (1) for that question on the answer sheet.

For each statement that DOES NOT AGREE with how you feel, circle the (0) for that question on the answer sheet.

81. Most of my classes are interesting.

82. I'm getting a good education.

83. Classes don't have much to do with what's happening.

84. Teachers don't care about students.

85. There are too many rules.

86. I like school.

87. Someone is always pushing drugs around my school.

88. I expect to graduate from high school.

89. I plan to go to college.

90. I expect to drop out of school to get a job.

91. I have trouble keeping up with my subjects.

92. What grade are you in this year?

1. 7th Grade
2. 8th Grade
3. 9th Grade
4. 10th Grade
5. 11th Grade
6. 12th Grade

93. What was your average grade last marking period?

1. A
2. B
3. C
4. D
5. F - Failure

94. In the past six months, I have drunk ALCOHOL:

1. Not at all
2. Less than once a month
3. About twice a month
4. About three times a month
5. About four or more times a month

95. When did you have your first DRINK of alcohol (beer, wine or liquor)?

1. This year (1971)
2. Last year (1970)
3. Two or three years ago (1968-69)
4. Four or five years ago (1966-67)
5. Five years ago or more (1965 or before)
6. I have not had alcohol at all.

96. When would you most likely drink?

1. Usually when I'm alone
2. When I'm with my close friends
3. Before, during and after a party
4. Anywhere away from home
5. Anytime outside school - doesn't matter
6. I don't drink.

97. If you have used ALCOHOL but have stopped, which of the following comes closest to your reason for stopping?

1. Thought it might be harmful or addictive.
2. My parents or others forced me to stop.
3. My friends wanted me to stop.
4. I'm no longer interested in drinking.
5. I have not stopped drinking.
6. I don't drink.

98. How much do your parents know about your drinking?

1. They don't know I drink.
2. They don't know I drink as much as I do.
3. They know I drink and want me to stop.
4. They know I drink and OK it.
5. I don't live with my parents.
6. I don't drink.

99. Which of these methods have you used MOST to get alcohol?

1. Said I was older or used an older person's ID card.
2. Had an older person buy it for me.
3. Friends gave it or sold it to me.
4. Parents gave it to me.
5. Bought it myself.
6. I don't drink.

100. Exactly how many times have you used marijuana and/or hashish?

0. Never used it
1. 1 or 2
2. 3 or 4
3. 5 or 6
4. 7 to 10
5. 11 to 20
6. 21 and more

101. When did you first use marijuana and/or hashish?

0. Never used it.
1. This year (1971)
2. Last year (1970)
3. Two or three years ago (1968-69)
4. Four or five years ago (1966-67)
5. Over five years ago (1965 or before)

102. If you have used Marijuana and/or hashish but have stopped, which one of the following comes closest to your reason for stopping?

0. Never used marijuana or hashish.
1. Thought it might be harmful or addictive.
2. My parents or others forced me to stop.
3. My friends wanted me to stop.
4. I'm not interested in using marijuana anymore.
5. I have not stopped using marijuana.

103. How much do your parents know about your using marijuana?

0. I never used it.
1. They don't know I use marijuana.
2. They don't know I use as much marijuana as I do.
3. They know I use marijuana and want me to stop.
4. They know I use marijuana and OK it.
5. I have no parents.

104. How difficult is it to obtain marijuana?

1. My friends give it to me for free.
2. I can buy it around school for what it costs my friends.
3. I have to buy it from people I don't know too well.
4. You have to know where to look for it.
5. It's very difficult to buy it.
6. I've never bought or been given marijuana or don't know.

105. Exactly on how many occasions have you sniffed solvents (glue, nail polish remover, paint thinner, etc.)?

0. Never
1. 1 or 2
2. 3 or 4
3. 5 or 6
4. 7 to 10
5. 11 to 20
6. 21 and more

106. How many boys in your class use ALCOHOL (beer, wine, liquor) once a week or more that you know of?

1. No boys that I know of
2. 1 to 2 boys
3. 3 to 4 boys
4. 5 to 9 boys
5. Almost half of the boys in the class
6. More than half of the boys in the class

107. How many girls in your class use ALCOHOL once a week or more that you know of?

    1. No girls that I know of
    2. 1 to 2 girls
    3. 3 to 4 girls
    4. 5 to 9 girls
    5. Almost half of the girls in the class
    6. More than half of the girls in the class

108. How many boys in your class use marijuana once a week or more that you know of?

    1. No boys that I know of
    2. 1 to 2 boys
    3. 3 to 4 boys
    4. 5 to 9 boys
    5. Almost half of the boys in the class
    6. More than half of the boys in the class

109. How many girls in your class use marijuana once a week or more that you know of?

    1. No girls that I know of
    2. 1 to 2 girls
    3. 3 to 4 girls
    4. 5 to 9 girls
    5. Almost half the girls in the class
    6. More than half the girls in the class

110. Exactly on how many occasions have you used LSD?

    0. Never
    1. 1 or 2
    2. 3 or 4
    3. 5 or 6
    4. 7 to 10
    5. 11 to 20
    6. 21 and more

111. How many boys in your class have used LSD once a month or more that you know of?

    1. No boys that I know of
    2. 1 or 2 boys
    3. 3 to 4 boys
    4. 5 to 9 boys
    5. Almost half the boys in the class
    6. More than half the boys in the class

112. How many girls in your class have used LSD once a month or more that you know of?

    1. No girls that I know of
    2. 1 or 2 girls
    3. 3 to 4 girls
    4. 5 to 9 girls
    5. Almost half of the girls in the class
    6. More than half the girls in the class

113. Obtaining LSD is:

1. Very difficult
2. Difficult
3. Not too difficult
4. Pretty easy
5. It's all over the school
6. I don't know

114. Exactly on how many occasions have you used Barbiturates (Downers)?

0. Never
1. 1 or 2
2. 3 or 4
3. 5 or 6
4. 7 to 10
5. 11 to 20
6. 21 and more

115. Obtaining BARBITURATES is:

1. Very difficult
2. Difficult
3. Not too difficult
4. Pretty easy
5. Simple - almost every home has some
6. I don't know

116. Exactly on how many occasions have you used Speed, "Ups", amphetamines (stimulants)?

0. Never
1. 1 or 2
2. 3 or 4
3. 5 or 6
4. 7 to 10
5. 11 to 20
6. 21 and more

117. Obtaining "Speed", Pep pills, stimulants, is:

1. Very difficult
2. Difficult
3. Not too difficult
4. Pretty easy
5. Simple
6. I don't know

118. Exactly on how many occasions have you used Heroin?

1. Not at all
2. 1 or 2
3. 3 or 4
4. 5 or more times

Questions 119 through 128.

For each of the following drugs, circle a (1) on the answer sheet next to the drug you used FIRST and a (2) to the drug you used SECOND and continue to do this for each drug you have ever used. If you have used only three drugs, they will be numbered from 1 (the drug you took first) to 3 (the one you took last). Leave blank any drugs you have not used.

119. Speed
120. Heroin
121. Tobacco (smoking)
122. Tranquilizers
123. Alcohol
124. LSD
125. Marijuana/Hashish
126. Other hallucinogens
127. Sniffed solvents
128. Barbiturates

Here are some statements about drugs, their effects and the laws governing their use. For each statement that AGREES with how you feel, circle the (1) for that question on the answer sheet. For each statement that DOES NOT AGREE with how you feel, circle the (0) for that question on the answer sheet. Leave blank any you don't know or are not sure of.

129. There is nothing wrong with smoking Marijuana as long as a person does so in moderation.

130. Everyone should try drugs at least once to find out what they are like.

131. Most people who smoke Marijuana use it for a long time but never try anything else.

132. Sniffing glue can damage the brain.

133. Education is the best way of preventing drug abuse.

134. Drug addicts should be treated as sick people and not as criminals.

135. Current laws regarding Marijuana use are too severe.

136. People can use drugs to find out more about themselves.

137. Current laws regarding heroin use are too severe.

138. Drug use should be a matter of personal decision.

139. A lot of people need drugs to cope with stress.

140. Most people who abuse drugs do so because their friends do.

141. Most people who smoke Marijuana use it for a while and then go on to something stronger.

142. Anyone can kick the drug habit whenever they want.

143. Do you know of local organizations and agencies that work with youthful drug offenders? How many?

0. None
1. 1 or 2
2. 3 or 4
3. 5 or more

144. What is the typical action taken by these agencies?

0. They do nothing
1. Talk
2. Medication
3. Call the police
4. Call the parents
5. I don't know

145. If your closest group of friends began to take drugs such as Marijuana, LSD or Heroin, what would you do?

1. Get out of the group
2. Try to influence them to stop
3. Join them in using drugs
4. Turn them in to the authorities
5. I don't know

Here are some reasons for possibly taking drugs. For each statement that you believe is basically TRUE, circle the (1) for that question on the answer sheet. For each statement that you believe is basically FALSE, circle the (0) for that question on the answer sheet.

146. Curiosity.

147. Everyone else does it, so he does it, too.

148. Relieves boredom.

149. To forget about problems.

150. Self-discovery.

151. To prove he's not afraid.

152. Just for kicks.

153. To get high.

154. It really can't hurt you.

155. It "blows" your mind.

158, 159, and 160. PLEASE ENTER THE SCHOOL IDENTIFYING NUMBER ON THE ANSWER SHEET AT 158, 159, and 160.

COLLEGE STUDENT QUESTIONNAIRE ABOUT DRUGS

This survey is an attempt to find out the knowledge, attitude and practices of students in Montgomery County with respect to drugs.

Your answer sheet will be anonymous and strictly confidential. Do not sign your name. There is no way your individual answer sheet can ever be identified. The page will be scored and then destroyed.

INSTRUCTIONS

A. You need three things: The Question Booklet
The Answer Sheet
A pencil and eraser.

B. The questions are numbered 1,2,3,4 etc.
The answer choices to each question are also numbered 1,2,3,4 etc.

C. For every question, circle the number identifying your answer on the answer sheet. Choose the ONE right or the best or the closest answer for you.

D. These are the STEPS IN ANSWERING:

1. Read the question CAREFULLY.
2. Read all the answer choices. Some are tricky or require thinking.
3. Match the question numbers in the QUESTION BOOKLET and ANSWER SHEET.
4. CIRCLE the NUMBER identifying your answer on the ANSWER SHEET.
5. If you make a mistake (such as if you mark the wrong number or mark the wrong question):
   a. Erase the mistake out completely.
   b. Circle the right number.

Question 1. Which is your age? Circle the number next to your age on your answer sheet. (For example, if your age is 15 years, circle the 4 next to Question 1.)

1. 12 years or under
2. 13 years
3. 14 years
4. 15 years
5. 16 years
6. 17 years
7. 18 years
8. 19 years
9. 20 years
0. 21 years or older

Question 2. Are you

1. Male
2. Female

Questions 3 to 13 ask about how you generally feel. If the statement made generally describes how you feel, circle (1) on the answer sheet next to the question number. If the statement DOES NOT generally describe how you feel, circle (0) on the answer sheet next to the question number.

AGREE (1)
DISAGREE (0)

How do you generally feel?

Question 3. Most of the time I am happy.

Question 4. Life is boring.

Question 5. Sometimes I like to do things that shock people.

Question 6. I have many friends.

Question 7. I have less fun than most people.

Question 8. Things generally work out the way I want them to.

Question 9. My parents often disapprove of my friends.

Question 10. I get a kick out of doing something my parents don't like.

Question 11. I seldom feel close to people.

Question 12. I can't control my life.

Question 13. My social life is satisfying.

Question 14. Of the people you know, how many do you consider to be CLOSE, PERSONAL FRIENDS?

1. One or two
2. Three or four
3. Five or more
4. None

15. Where do you live?

    4. On campus - dormitory
    5. On or off campus - fraternity or sorority
    6. Off campus - private housing
    7. Off campus - at home

16. NO ANSWER REQUIRED

17. NO ANSWER REQUIRED

Questions 18 to 31 ask about things that are of concern to most young people today. If the subject covered by the statement CONCERNS YOU A GREAT DEAL, CIRCLE (2) NEXT TO THE QUESTION NUMBER ON THE ANSWER SHEET.

If the subject covered by the statement is OF SOME CONCERN TO YOU but NOT A GREAT DEAL OF CONCERN, CIRCLE (1) NEXT TO THE QUESTION NUMBER ON THE ANSWER SHEET.

If the subject covered by the statement is OF NO CONCERN TO YOU, CIRCLE (0) ON THE ANSWER SHEET NEXT TO THE QUESTION NUMBER.

Great deal of concern to me - 2
Some concern to me - 1
Of no concern to me - 0

18. Deciding what I want to do with my life.

19. Having enough money.

20. Getting good grades.

21. Making friends.

22. Getting along with parents.

23. Getting involved with drugs.

24. Being drafted.

25. Getting a job.

26. Being arrested.

27. Having a good time

28. Living up to my religious or moral training.

29. Air and water pollution.

30. Unemployment

31. Racial inequality.

32. I am -

1. Black
2. White
3. Oriental
4. American Indian
5. Puerto Rican
6. None of these

33. What language do your parents speak most of the time?

1. English only
2. Italian, Spanish, Portuguese
3. Jewish, Hebrew
4. German, French, Scandinavian Languages
5. Chinese or Japanese
6. Polish, Czechoslovakian, Hungarian, Romanian, Ukranian, Russian, Greek
7. None of these

34. What is your FAMILY RELIGION? (Religion practiced in your home.)

1. Catholic
2. Protestant (Anglican, Presbyterian, United, Baptist, etc)
3. Jewish
4. Quaker
5. No religion
6. Other
7. I don't know

35. Do you attent services?

1. Regularly by myself.
2. Regularly with some members of my family.
3. Not at all but belong to a religious group.
4. Not at all and do not belong to a religious group.
5. Regularly with friends.

36. With whom were you raised?

1. Both parents
2. Mother alone (Parents divorced or separated)
3. Father alone (Parents divorced or separated)
4. Mother alone (Father has died)
5. Father alone (Mother has died)
6. Mother and Stepfather
7. Father and Stepmother
8. Other relative
9. None of these

37. Are you -

1. The only child
2. The oldest child
3. The youngest child
4. Between the oldest and the youngest.

38. NO ANSWER REQUIRED

39. How far did your father go in school?

1. Eighth grade or less
2. Some high school
3. High school graduate
4. Some college
5. College graduate
6. Some graduate study
7. Graduate or professional degree
8. I don't know

40. How far did your mother go in school?

1. Eighth grade or less
2. Some high school
3. High School graduate
4. Some college
5. College graduate
6. Some graduate study
7. Graduate or professional degree
8. I don't know

41. What kind of work does your FATHER do?

1. Farmer
2. Semi-skilled (Construction, driving, shipping, general labor)
3. Skilled or Technical (Mechanic, electrician, baker, machine operator)
4. Proprietor (store or small business owner)
5. Clerical or Sales (Bookkeeper, office work, salesman)
6. Professional and Managerial (Doctor, teacher, manager)
7. None of these, Father does not work or has no father.

42. NO ANSWER REQUIRED

43. NO ANSWER REQUIRED

44. How would you describe your family?

1. We are very close.
2. We are somewhat close.
3. We are not too close.
4. We are not close at all.

45. To whom would you most likely go in your family for advice or help?

1. Anyone in the family
2. Just my mother and father
3. Just my mother
4. Just my father
5. Any brother or sister
6. A certain brother or sister
7. Another relative
8. No one in the family

46. Does your father drink alcoholic beverages?

0 - Never
1 - Sometimes - not very often
2 - Often
3 - No father or father not living at home

47. Does your father get drunk?

0 - Never
1 - Sometimes, not very often
2 - Often
3 - No father or father not living at home.

48. Does your father participate in community activities such as Little League, Volunteer Firemen, Lions Club, etc.?

0 - Never
1 - Sometimes, not very often
2 - Often
3 - No father or father not living at home

49. Does your father take tranquilizers, pills and/or medicines?

0 - Never
1 - Sometimes, not very often
2 - Often
3 - No father or father not living at home.

50. Does your father smoke (cigarettes, pipes, cigars)?

0 - Never
1 - Sometimes, not very often
2 - Often
3 - No father or father not living at home

51. Does your mother drink alcoholic beverages?

0 - Never
1 - Sometimes, not very often
2 - Often
3 - No mother or mother not living at home.

52. Does your mother belong to social clubs?

0 - None
1 - A few (1 or 2)
2 - Many (3 or more)
3 - I don't know - no mother - mother not living at home

53. NO ANSWER REQUIRED

54. Does your mother get drunk?

0 - Never
1 - Sometimes, not very often
2 - Often
3 - Mother not living at home, no mother

55. Does your mother take tranquilizers, pills and/or medicines?

0 - Never
1 - Sometimes, not very often
2 - Often
3 - Mother not living at home - no mother.

56. What are your sources of spending money? (excluding tuition room & board)

1. Allowance from parents only
2. Allowance and job
3. Job only
4. Other source
0. I don't get any spending money.

57. How much money do you have to spend each WEEK?

4. $ 5.01 to $10.00
5. $ 10.01 to $20.00
6. More than $20.00 per week
0. I don't get any money to spend.

58. What do you most often do in the evenings?

6. Study at place of residence.
7. Study with others, outside of place of residence.
8. Participate in organized campus activities.
9. Spontaneous activities - just goofing off.

59. If my friends smoke cigarettes, I would feel -

1. that I want to do the same.
2. it's OK but I don't want to do the same.
3. that I wish they wouldn't do it.
4. I don't care what they do.

60. If my friends drink alcohol, I would feel -

1. that I want to do the same.
2. it's OK but I don't want to do the same.
3. that I wish they wouldn't do it
4. that I don't care what they do.

61. If my friends smoke marijuana or hashish, I would feel -

1. that I want to do the same.
2. it's OK but I don't want to do the same.
3. that I wish they wouldn't do it.
4. I don't care what they do.

62. NO ANSWER REQUIRED

63. If my friends used LSD, I would feel -

1. that I want to do the same.
2. it's OK but I don't want to do the same.
3. that I wish they wouldn't do it.
4. I don't care what they do.

64. If my friends used Barbiturates (Downers), I would feel -

    1. that I want to do the same.
    2. it's OK but I don't want to do the same.
    3. that I wish they wouldn't do it.
    4. I don't care what they do.

65. If my friends used Speed (Amphetamines), I would feel -

    1. that I want to do the same
    2. it's OK but I don't want to do the same
    3. that I wish they wouldn't do it
    4. I don't care what they do.

66. If my friends used Heroin, I would feel -

    1. that I want to do the same
    2. it's OK but I don't want to do the same
    3. that I wish they wouldn't do it
    4. I don't care what they do.

67. NO ANSWER REQUIRED

68. NO ANSWER REQUIRED

69. How often have you been at a party where drugs were used?

    1. Never
    2. One or two times
    3. Three to five times
    4. Six times or more
    5. I'm not sure if drugs were used.

70. From which ONE of the following sources have you learned the MOST of what you know about drugs?

    1. From church or school
    2. From my family
    3. From the people I associate with
    4. From TV, radio, newspapers, magazines
    5. From my own experience with drugs.

Suppose each of the following groups of people gave you advice on the use and abuse of drugs. To whom would you listen?

71. Would you listen to advice from your father or mother? 1. Yes 0. No

72. Police officer, lawyer or judge? 1. Yes 0. No

73. Teacher or school counselor? 1. Yes 0. No

74. Minister, priest or rabbi? 1. Yes 0. No

75. Older brother or sister? 1. Yes 0. No

76. A friend or fellow student? 1. Yes 0. No

77. Someone who has used drugs? 1. Yes 0. No

78. ON THE BOARD IN FRONT OF THE ROOM IS A NUMBER IDENTIFYING
79. THIS SCHOOL. PLEASE WRITE THAT NUMBER ON YOUR ANSWER SHEET
80. AT 78,79,80.

Here are some statements about your possible feelings about college. For each statement that AGREES with how you feel, circle the (1) for that question on the answer sheet.

For each statement that DOES NOT AGREE with how you feel, circle the (0) for that question on the answer sheet.

81. Most of my classes are interesting.

82. I'm getting a good education.

83. Classes don't have much to do with what's happening.

84. Professors don't care about students.

85. There are too many rules.

86. I like college.

87. Someone is always pushing drugs around my campus.

88. I expect to graduate from college.

89. I plan to go to graduate school.

90. I expect to drop out of college to get a job.

91. I have trouble keeping up with my subjects.

92. What year of college are you in, now?

7. Freshman
8. Sophomore
9. Junior
0. Senior

93. What was your grade average last semester?

1. A
2. B
3. C
4. D
5. F - Failure

94. In the past six months, I have drunk alcohol:

1. Not at all
2. Less than once a month.
3. About twice a month
4. About three times a month
5. About four or more times a month

95. When did you have your first DRINK of alcohol? (beer, wine or liquor)

1. This year, 1971
2. Last year, 1970
3. Two or three years ago, 1968-69
4. Four or five years ago, 1966-67
5. Five years ago or more, 1965 or before
6. I have not had alcohol at all.

96. When would you most likely drink?

1. Usually when I'm alone.
2. When I'm with my close friends.
3. Before, during and after a party.
4. Anywhere away from home.
5. Anytime outside classes - doesn't matter
6. I don't drink.

97. If you have used ALCOHOL but have stopped, which of the following comes closest to your reason for stopping?

1. Thought it might be harmful or addictive.
2. My parents or others forced me to stop.
3. My friends wanted me to stop.
4. I **am no longer interested in** drinking.
5. I have not stopped drinking.
6. I don't drink.

98. How much do your parents know about your drinking?

1. They don't know I drink.
2. They don't know I drink as much as I do.
3. They know I drink and want me to stop.
4. They know I drink and OK it.
5. I don't live with my parents.
6. I don't drink.

99. Which of these methods have you used MOST to get alcohol?

1. Said you were older or used an older person's ID card.
2. Had an older person buy it for you.
3. Friends gave it or sold it to you.
4. Parents gave it to you.
5. Bought it yourself.
6. I don't drink.

100. Exactly how many times have you used marijuana and/or hashish?

0. Never used it
1. One or two
2. Three or four
3. Five or six times
4. Seven to ten times
5. 11 to 20
6. 21 and more

101. When did you first use marijuana and/or hashish?

0. Never used it.
1. This year, 1971
2. Last year, 1970
3. Two or three years ago, 1968-69
4. Four or five years ago, 1966-67
5. Over five years ago, 1965 or before

102. If you have used marijuana and/or hashish, but have stopped, which one of the following comes closest to your reason for stopping?

0. Never used marijuana and/or hashish
1. Thought it might be harmful or addictive
2. My parents or others forced me to stop
3. My friends wanted me to stop
4. I'm not interested in using marijuana anymore
5. I have not stopped using marijuana

103. How much do your parents know about your using marijuana?

0. Never used it.
1. They don't know I used marijuana.
2. They don't know I use marijuana as much as I do.
3. They know I use marijuana and want me to stop
4. They know I use marijuana and OK it.
5. I have no parents.

104. How difficult is it to obtain marijuana?

1. My friends give it to me for free.
2. I can buy it around campus for what it cost my friends.
3. I have to buy it from people I don't know too well.
4. You have to know where to look for it.
5. It's very difficult to buy it.
6. I've never bought nor been given marijuana.

105. Exactly on how many occasions have you sniffed solvents - glue, nail polish remover, paint thinner, etc. ?

0. Never
1. One or two
2. Three or four
3. Five or six
4. Seven to ten
5. 11 to 20
6. 21 and more

106. How many men in your class use Alcohol (beer, wine, liquor) once a week or more that you KNOW of?

1. No men that I know
2. One or two men
3. Three or four men
4. Five to nine men
5. Almost half of the men in the class
6. More than half of the men in the class

107. How many women in your class use alcohol once a week or more that you KNOW of ?

1. No women that I know of
2. One or two women
3. Three or four women
4. Five to nine women
5. Almost half of the women in the class
6. More than half of the women in the class

108. How many men in your class use marijuana once a week or more that you KNOW of?

1. No men that I know of
2. One or two men
3. Three or four men
4. Five to nine men
5. Almost half of the men in the class
6. More than half of the men in the class

109. How many women in your class use marijuana once a week or more that you KNOW of?

1. No women that I know of
2. One or two women
3. Three or four women
4. Five to nine women
5. Almost half of the women in the class
6. More than half of the women in the class

110. Exactly on how many occasions have you used LSD?

0. Never
1. One or two
2. Three or four
3. Five or six
4. Seven to ten
5. 11 to 20
6. 21 and more

111. How many men in your class have used LSD once a month or more that you know of?

1. No men that I know of
2. One or two men
3. Three or four men
4. Five to nine men
5. Almost half of the men in the class
6. More than half of the men in the class

112. How many women in your class have used LSD once a month or more that you KNOW of?

1. No women that I know of.
2. One or two women
3. Three or four women
4. Five to nine women
5. Almost half of the women in the class
6. More than half of the women in the class

113. Obtaining LSD is -

1. Very difficult
2. Difficult
3. Not too difficult
4. Pretty easy
5. It's all over the campus
6. I don't know

114. Exactly on how many occasions have you used Barbiturates - Downers ?

0. Never
1. One or two
2. Three or four
3. Five or six
4. Seven to ten
5. 11 to 20
6. 21 and more

115. Obtaining Barbiturates is -

1. Very difficult
2. Difficult
3. Not too difficult
4. Pretty easy
5. Simple - almost every home has some
6. I don't know

116. Exactly on how many occasions have you used Speed, Ups, stimulants, amphetamines ?

0. Never
1. One or two
2. Three or four
3. Five or six
4. Seven to ten
5. 11 to 20
6. 21 and more

117. Obtaining "speed", pep pills, stimulants, is -

1. Very difficult
2. Difficult
3. Not too difficult
4. Pretty easy
5. Simple
6. I don't know

118. Exactly on how many occasions have you used Heroin?

1. Not at all
2. One or two
3. Three or four
4. Five or more times

Questions 119 through 128

For each of the following drugs, circle a (1) on the answer sheet next to the drug you used FIRST and a (2) next to the drug you used SECOND and continue to do this for each drug you have ever used.

If you have used only three drugs, they will be numbered from 1 (the drug you took first) to 3 (the one you took last). Leave blank any drugs you have not used.

119. Speed
120. Heroin
121, Tobacco (smoking)
122. Tranquilizers
123. Alcohol (beer, wine, liquor)
124. LSD
125. Marijuana/Hashish
126. Other hallucinogens
127. Sniffed solvents
128. Barbiturates

Here are some statements about drugs, their effects and the laws governing their use. For each statement that AGREES with how you feel, circle the (1) for that question on the answer sheet. For each statement that DOES NOT AGREE with how you feel, circle the (0) for that question on the answer sheet. Leave blank any you don't know or are not sure of.

129. There is nothing wrong with smoking marijuana as long as a person does so in moderation.

130. Everyone should try drugs at least once to find out what they are like.

131. Most people who smoke marijuana use it for a long time but never try anything else.

132. Sniffing glue can damage the brain.

133. Education is the best way of preventing drug abuse.

134. Drug addicts should be treated as sick people and not as criminals.

135. Current laws regarding marijuana use are too severe.

136. People can use drugs to find out more about themselves.

137. Current laws regarding heroin use are too severe.

138. Drug use should be a matter of personal decision.

139. A lot of people need drugs to cope with stress.

140. Most people who abuse drugs do so because their friends do.

141. Most people who smoke marijuana use it for a while and then go on to something stronger.

142. Anyone can kick the drug habit whenever they want to.

143. Do you know of local organizations and agencies that work with youthful drug offenders? How many?

0. None
1. One or two
2. Three or four
3. Five or more

144. What is the typical action taken by these agencies?

0. They do nothing
1. Talk
2. Medication
3. Call the police
4. Call the parents
5. I don't know

145. If your closest group of friends began to take drugs such as marijuana, LSD or Heroin, what would you do?

1. Get out of the group
2. Try to influence them to stop
3. Join them in using drugs
4. Turn them in to the authorities
5. I don't know

Here are some reasons for possibly taking drugs. For each statement that you believe is basically TRUE, circle the (1) for the question on the answer sheet. For each statement that you believe is basically FALSE, circle the (0) for that question on the answer sheet.

146. Curiosity

147. Everyone else does it, so he does it, too.

148. Relieves boredom

149. To forget about problems

150. Self-discovery

151. To prove he's not afraid

152. Just for kicks

153. To get high

154. It really can't hurt you.

155. It blows your mind.

158,159 and 160. PLEASE ENTER THE SCHOOL IDENTIFYING NUMBER ON THE ANSWER SHEET AT 158, 159 and 160.

THANK YOU.

PLEASE MAKE SURE YOU HAVE NOT WRITTEN YOUR NAME ON THE ANSWER SHEET. IF YOU HAVE, ERASE IT NOW.

WHEN YOU HAVE FINISHED, GIVE THE ANSWER SHEET AND QUESTION BOOKLET TO THE SURVEY ADMINISTRATOR.

Quest. No.	Choices
1.	1 2 3 4 5 6 7 8 9 0
2.	1 2
3.	1 0
4.	1 0
5.	1 0
6.	1 0
7.	1 0
8.	1 0
9.	1 0
10.	1 0
11.	1 0
12.	1 0
13.	1 0
14.	1 2 3 4
15.	1 2 3 4 5 6 7
16.	1 2 3 4 5 6
17.	1 2 3 4
18.	2 1 0
19.	2 1 0
20.	2 1 0
21.	2 1 0
22.	2 1 0
23.	2 1 0
24.	2 1 0
25.	2 1 0
26.	2 1 0
27.	2 1 0
28.	2 1 0
29.	2 1 0
30.	2 1 0
31.	2 1 0
32.	1 2 3 4 5 6
33.	1 2 3 4 5 6 7
34.	1 2 3 4 5 6 7
35.	1 2 3 4 5
36.	1 2 3 4 5 6 7 8 9
37.	1 2 3 4
38.	0 1 2 3 4
39.	1 2 3 4 5 6 7 8
40.	1 2 3 4 5 6 7 8
41.	1 2 3 4 5 6 7
42.	1 2 3 4 5
43.	1 2 3 4 5
44.	1 2 3 4
45.	1 2 3 4 5 6 7 8
46.	0 1 2 3
47.	0 1 2 3
48.	0 1 2 3
49.	0 1 2 3
50.	0 1 2 3
51.	0 1 2 3
52.	0 1 2 3
53.	0 1 2 3
54.	0 1 2 3
55.	0 1 2 3
56.	0 1 2 3 4
57.	1 2 3 4 5 6 7 8 9 0
58.	1 2 3 4 5 6 7 8 9
59.	1 2 3 4
60.	1 2 3 4
61.	1 2 3 4
62.	1 2 3 4
63.	1 2 3 4
64.	1 2 3 4
65.	1 2 3 4
66.	1 2 3 4
67.	1 2 3 4
68.	1 2 3 4
69.	1 2 3 4 5
70.	1 2 3 4 5
71.	1 0
72.	1 0
73.	1 0
74.	1 0
75.	1 0
76.	1 0
77.	1 0
78.	
79.	
80.	

Quest. No.	Choices
81.	1 0
82.	1 0
83.	1 0
84.	1 0
85.	1 0
86.	1 0
87.	1 0
88.	1 0
89.	1 0
90.	1 0
91.	1 0
92.	1 2 3 4 5 6 7 8 9 0
93.	1 2 3 4 5
94.	1 2 3 4 5
95.	1 2 3 4 5 6
96.	1 2 3 4 5 6
97.	1 2 3 4 5 6
98.	1 2 3 4 5 6
99.	1 2 3 4 5 6
100.	0 1 2 3 4 5 6
101.	0 1 2 3 4 5
102.	0 1 2 3 4 5
103.	0 1 2 3 4 5
104.	1 2 3 4 5 6
105.	0 1 2 3 4 5 6
106.	1 2 3 4 5 6
107.	1 2 3 4 5 6
108.	1 2 3 4 5 6
109.	1 2 3 4 5 6

Quest. No.	Choices
110.	0 1 2 3 4 5 6
111.	1 2 3 4 5 6
112.	1 2 3 4 5 6
113.	1 2 3 4 5 6
114.	0 1 2 3 4 5 6
115.	1 2 3 4 5 6
116.	0 1 2 3 4 5 6
117.	1 2 3 4 5 6
118.	1 2 3 4
119.	1 2 3 4 5 6 7 8 9 0
120.	1 2 3 4 5 6 7 8 9 0
121	1 2 3 4 5 6 7 8 9 0
122	1 2 3 4 5 6 7 8 9 0
123	1 2 3 4 5 6 7 8 9 0
124	1 2 3 4 5 6 7 8 9 0
125	1 2 3 4 5 6 7 8 9 0
126	1 2 3 4 5 6 7 8 9 0
127	1 2 3 4 5 6 7 8 9 0
128	1 2 3 4 5 6 7 8 9 0
129	1 0
130	1 0

Quest. No.	Choices
131	1 0
132	1 0
133	1 0
134	1 0
135	1 0
136	1 0
137	1 0.
138	1 0
139	1 0
140	1 0
141	1 0
142	1 0
143	0 1 2 3
144	0 1 2 3 4 5
145	1 2 3 4 5
146	1 0
147	1 0
148	1 0
149	1 0
150	1 0
151	1 0
152	1 0
153	1 0
154	1 0
155	1 0
158 159 160	________

FINDINGS AND RECOMMENDATIONS

A SURVEY OF DRUG USAGE AND ABUSE IN MONTGOMERY COUNTY, PENNSYLVANIA

Consultants' Findings

The Montgomery County Drug Commission concurs with the following recommendations submitted by SRI-Human Systems Institute as a result of the survey done in Montgomery County:

"The authors' recommendations fall into two categories. Based on an analysis of the data in this study, we will recommend programmatic approaches to be used to reduce the incidence of drug abuse in Montgomery County. In addition, our recommendations for further research are also included so that specific variables not covered by the above study, but which seem to be significant for a further understanding of the drug problem in Montgomery County, can be researched and explored.

Programmatic Recommendations

"It is recommended that a central training agency be created under the aegis of a County Commission or a local college or junior college. This agency would have as its primary responsibility the dissemination of scientifically validated information regarding drug abuse and would assume responsibility for the development of tailor-made training programs which would assist law enforcement agents, court personnel, school personnel, and social agency professionals in acquiring the necessary information and skills with which they can combat drug abuse in Montgomery County. In addition, this agency would serve as a coordinating body insuring that programs are relevant and effective and are integrated with other programs.

"An analysis of the research data included in this study indicates that much of the effort presently being made to fight drug abuse in Montgomery County is not dealing with the basic causative factors. The data consequently has significant and serious implications for all relevant County, municipal, and private agency employees whose responsibility it is to deal with the drug offender and the drug problem. Our social agency interviews, for example, indicate that the prevention of drug abuse in Montgomery County is receiving almost no attention as compared with the attempts at providing treatment for already existing offenders.

"Assuming the validity of the study data, it is apparent that preventive measures need to be directed at strengthening the relevant social institutions in the County, since it is the breakdown of these institutions which is the primary cause of drug abuse.

"Suggested implications of the findings for the major agencies and institutions which are presently dealing with the drug problem are as follows:

1. Police, Law Enforcement Agencies, and Courts

> "These agencies must contend with the findings of the study which indicate no relationship between availability of

drugs and its usage (other than marijuana in high schools). Consequently, utilizing disproportionate resources for drying up the sources might be a misdirection of the energies of law enforcement personnel. The implications of these findings must be evaluated by law enforcement officials. In addition, the fact that a large portion of the Montgomery County student body (21.2% high school students--37% college students) are using marijuana to a high degree and therefore are violating the law, needs to be analyzed in terms of its implications on the whole question of law-abiding behavior in Montgomery County.

"It is recommended that a one-day institute be assembled of law enforcement and court officials to evaluate the significance of this data in relation to their current function. Hopefully, the participants will obtain greater insight into the total drug abuse problem and into their role in combatting it.

2. The Schools

"An analysis and interpretation of the study data indicates that drug education programs administered by school systems have missed the mark. Individual interviews with students often revealed their feeling that these programs have been inadequate and, in some cases, have actually provided the information the youngster needed in order to experiment with drugs. For the most part, drug education programs have attacked the symptoms but not the causes. The need to deal with the total child rather than information as such seems to be a clear implication of the study data. We recommend that drug education programs be developed which focus upon assisting the child in strengthening his own level of self-confidence and his ties to community institutions. This is particularly critical since drug abuse is revealed by this study to be directly related to boredom and dissatisfaction with school. In this connection it would be helpful to develop such programs in conjunction with basic mental health concepts--perhaps in cooperation with available mental health agencies.

"In addition, an effort should be made to provide group programs for parents in order to strengthen family cohesion and parental understanding of why their children might use drugs. Such parental education programs could be designed in such a manner so as to include children as well, thereby attempting to strengthen the parent-child relationship through the use of dialogues and group programs. In addition, drug education programs should emphasize developing positive peer group influences, since the peer group plays a significant role in encouraging drug usage. It is within the context of this form of drug education which deals with the total child, his family, and his peer group, that drug information can be more relevantly disseminated to both parent and child alike.

"A side effect of a positive drug education program is the need to assist educators in identifying drug users so that appropriate referrals can be made.

"In order for the above described approaches to be utilized within the school setting, it would be necessary for school personnel to be adequately trained in group techniques and in the application of realistic knowledge of drug abuse to the total child. We propose that the "umbrella" training agency recommended above be charged with this responsibility. At the present time, it is unlikely that there are sufficient school personnel who have the skills to perform the type of drug education described above.

"To initiate the effort for improved participation of school personnel in combatting drug abuse, we recommend a one-day institute of school superintendents so that the study data can be reviewed and their role in relation to causative and preventive factors can be evaluated.

3. Social Agencies

"There is every reason to believe that the social agencies in Montgomery County are similarly ill-equipped with knowledge and skills to deal with the present drug problem. Their role in preventing drug abuse can be crucial--particularly in strengthening family cohesion and redirecting peer group influences. It is recommended that a one-day institute be assembled with the participation of family agency officials. This institute would have as its objectives an evaluation of the survey data and a reassessment of the role of the family agency in combatting drug abuse and in strengthening, wherever possible, the social institutions in their community. The social agencies of Montgomery County can play a major role in the treatment and prevention of drug abuse providing they mount a planned and coordinated approach to the problem.

4. Probation and Parole Agencies

"The probation and parole services of Montgomery County can play a significant role in combatting drug abuse. Many youngsters and adults who are drug offenders are known to these agencies. There is little evidence that legal or punitive action has a deterring effect on most individual users. The probation and parole officer has a legal relationship to the user and, given adequate resources and training, he has the opportunity to impact on the problem. Group treatment approaches such as Guided Group Interaction can strengthen the peer group's influence on the individual user. It is recommended that select probation and parole officers be trained in these approaches. In addition, given the strengthening of other community services, these professionals can serve as an excellent referral agent.

"We recommend that a one-day institute be held so that probation and parole officials can be appraised of the study data and so that they can reassess their role in the overall community fight against drugs.

5. The Churches

"The study data clearly indicates that youngsters who are significantly involved in a church experience tend not to use drugs. This has significant implications for the fight against drug abuse. We recommend that in a one-day institute attended by Montgomery County church and synagogue leaders this data be reviewed and a program be developed for the further strengthening of church and synagogue programs which serve youth in the County.

6. Hospitals, Physicians, and Psychotherapists

"The identification and treatment of the drug offender frequently involves medical and psychological factors. In an effort to enlist the aid of physicians, psychologists, social workers, etc., we propose that a one-day institute be held for these professionals so that they can evaluate the implications of the study data and so that coordination of their efforts can be accomplished. Private physicians and psychologists are in a unique position to assist in identifying family and individual problems which are contributing to drug usage.

Recommendations for Future Research

1. "A review of the comparative school data found in the study revealed that there were several instances where two schools were in close geographic proximity to each other and one school had a high rate of drug usage while the other had a low rate. Since there were little discernible differences between the schools with regard to race, socioeconomic data, and other variables, it would be extremely useful to examine these school pairs to determine why one school has a high drug usage and the other a low drug usage.

2. "We recommend that further research be conducted to ascertain just exactly what is a cohesive family and what are the reasons which explain why a cohesive family reduces drug abuse. Such an in-depth study--a small one--would be minor in nature, requiring limited resources, but might be extremely significant in its payoff.

3. "We recommend that further research be conducted on how the peer group can be altered within a school setting. Impacting on the peer group at the junior high school level might be extremely significant, since most drug abuse occurs at the age of 16 years and over.

4. "We recommend that all programs which are developed out of the findings of this study have an evaluation mechanism and design built in so that its effectiveness and limitations can be properly assessed. This will enable the program to learn from its mistakes and will enable the replication of techniques which work.

Summary

"It is the authors' recommendation that six one-day institutes be held where the data and findings of the study will be shared with community, County, and municipal professionals, and that each of these institutes be designed in such a manner so as to elicit their reaction to the data and their recommendations for the application of the data in their own areas or functions. It is also recommended that an "umbrella" training agency be created which would disseminate information on an ongoing basis and which would coordinate all efforts leading toward the prevention and control of drug abuse. This training agency would be responsible for transmitting the latest techniques to the relevant groups or professionals and technicians so that the war against drug abuse will be equipped with efforts based on facts and skills, rather than hope and mythology."

The Commission's Findings

The Drug Commission has found that controlling law is not consistent in its penalties to the detrimental effect of the drug controlled. Marijuana is classified as a narcotic, yet it has neither the effects nor properties of a narcotic. The medical and legal definitions must be brought into conformity, and the penalties should reflect the effect of the drug. The punishment should fit the crime.

The controlling law is too harsh with respect to marijuana in comparison to other more dangerous drugs. An individual could go to jail for two to five years for marijuana, whereas he might get only one year for methedrine which, in the opinion of the Commission, is a more immediate threat to life than marijuana. Thus, the Commission found that a revision of existing penalties with a greater emphasis on education and rehabilitation should be adopted.

Marijuana should not be legalized. Recent studies have indicated that prolonged use of marijuana may lead to motivational deterioration, impeded adolescent development, ego decompensation, and in some cases psychosis. More follow-up research should be undertaken to confirm or deny these findings.

The Commission found that there should be a continued distinction in penalties between users and traffickers of drugs. While the user is hurting himself and others, the trafficker is inflicting hardship on others for monetary gain only. Drug users and addicts who have not committed other crimes should be considered sick people in need of psychiatric attention, not criminals. The amount of trouble and hardship inherent in maintaining a habit is such that only a sick person could continue to act in this manner.

Recommendations

1. Drug users and addicts are persons who should be viewed as sick. The deviant behavior is induced by psychological and physical disorders which must be evaluated, diagnosed, and treated accordingly. In a few cases, imprisonment may be viewed as a therapeutic treatment approach, but under no circumstances should prisons be viewed as a solution. In cases where prisons are utilized to house drug users, a total drug treatment program must be available to assist in the rehabilitation process of the individual.

2. Legislative action must be taken immediately to provide funds to the Criminal Justice system for drug treatment facilities. To incarcerate a drug user without treatment services must be considered by the people as excessive and cruel punishment.

3. A distinction should be made between drug pushers who sell illegal drugs for profit and drug pushers who sell to support their habit. In the first case, the act should constitute a felony offense. In the latter case, the act should constitute a felony offense precipitated by sickness.

4. Legislative action should be passed immediately to allow researchers to investigate the effects and properties of all drugs of abuse including marijuana. Without appropriate research findings, it will be impossible to pass appropriate drug laws.

5. All drugs, including marijuana, should be reclassified and redefined under present legislation to bring the legal definition into realistic conformity with chemical and medical definitions. To classify a substance a narcotic when it in no way resembles a narcotic substance defies logic.

6. Legislation should be developed to limit drug advertisement in the mass media to a minimum and restrict the companies' claims to the facts of their products when advertised. Too often, the drug commercial implies that the medication will artificially solve all problems.

7. The Commission supports Pennsylvania House Bill 850 with the following reservations:

   a. Section 12 (d)

      Provides that any person assisted under this act may be required to contribute to the cost of his subsistence, etc., to the extent that he is financially able to do so under appropriate regulations. The regulations may provide for the utilization of funds available to such persons from certain listed sources, including "welfare." The Commission feels that welfare benefits should not be invaded for this purpose.

   b. Section 13 (2) (1)

      The provision therein that one who "appears" to be a drug-related misdemeanor lacks sufficient definition and makes one fear that the rights of the individual could be abused when the only controlling word is "appears." The Commission is of the opinion that an attempt should be made by the drafters of the legislation to specifically define "appears."

   c. Section 13 (2) (1)

      The last sentence of this subsection [(a) (1)] provides under certain circumstances that an individual may be detained for emergency medical treatment and diagnosis for a period of no longer than ten days. It is to be noted that an individual's liberty may be taken away from him for a period up to ten days simply if, after admission and immediate examination, a determination is made that "it is probable that he is a drug or alcoholic abuser or a drug or alcoholic dependent person who is in need of emergency medical services." We view with alarm any situation where a person's liberty may be taken away for a period as long as ten days as a result of an examination "which we assume to be medical" and where the finding of said medical examination is "probable." Thus, one person's "probable" finding may deprive an individual of ten days of liberty. We suggest that the drafters of this legislation give serious consideration to providing a requirement in accordance with the Mental Health-Mental Retardation Act of 1966 (Section 405) before detaining an individual for as long as ten days for emergency treatment. A commitment of such duration should not rest upon the "probable" opinion of one individual.

8. The Commission supports Pennsylvania House Bill 851 with the following reservations:

    a. With reference to possession and/or use of marijuana, a first offender should be treated as a summary proceedings to be disposed of before a district justice with a fine of no more than $100. The Commission recognizes that the district justice is not a court of record and also recognizes that there must be some record in order to determine whether an individual is a first offender or a multiple offender. The legislation should provide for a central record-keeping arrangement from which one could determine the number of offenses under this Act of each individual.

    b. It follows that the penalty provision in Pennsylvania House Bill 851 should be applicable to second offenders so that a second offense of possession and/or use of marijuana shall be a misdemeanor.

EDUCATION

The Commission's Findings

In the Drug Commission's opinion, educational approaches to drug abuse, if done in an honest and meaningful way, are one of the most vital tools available in preventing drug abuse. It is critical that these approaches not be sterile in their presentation and that material be based on the latest research.

There are three general groups at which educational approaches on drug abuse should be directed. They are the school population and staff, the parental community, and the social and political leadership.

It is strongly believed by the Commission that much of the effort that must go into a school program should be spent prior to the addiction of the individual. There is no question that at some point in an individual's development, he will have to confront the realities of using street drugs. If in his development, he has not been prepared for that decision, he will be that much closer to becoming a potential drug consumer. Thus, appropriate and relevant educational programs can be instrumental in preparing an individual with positive attitudinal views against drug use.

The Drug Commission has found that educational programs on drug abuse in the schools should reflect only one part of their efforts to prevent drug taking. The Commission, in looking beyond the system of drug taking, has heard much said about the "youth problems." In the Commission's opinion, you cannot separate drug taking behavior from the total child and his problems. There is sufficient evidence available in the study to show that there is a direct relationship between these two variables. It would thus behoove the schools to address themselves to developing programs to deal with youth conflicts and problems in their total environment while providing information on drug abuse. Both play a direct role in drug abuse and any attempt to deal with one must eventually include the other. Schools must not only attempt to inform their students about drugs but must also attempt to provide them with alternatives to drugs within their own system and community.

To date, the school districts of Montgomery County have taken a fragmented approach to drug education. In some cases, districts have contracted with outside agencies to develop programs for their pupils and teachers while others have developed their own. On a County-wide basis, however, there is a total lack of coordination and uniformity in either type of program or information content. The lack of coordination and uniformity in drug education approaches was especially documented in the study through personal student interviews. The greater majority of the 187 students interviewed viewed present programs as meaningless and ineffectual. In many cases, interviewees either laughed about their schools' efforts or reported it tempted them to try drugs.

It was also felt by the Commission that teachers are, for the most part, totally unprepared to deal with the questions of drug abuse. This is not only true of practicing, experienced teachers but also of new teachers.

A survey of area colleges and graduate teacher programs revealed that little or no preparation is being given to student teachers in the area of drug abuse information. Only one undergraduate college reported that they had training, and that program had been terminated due to lack of qualified staff. One graduate program reported that they had a one week course available.

The Commission felt that in some cases the services of ex-addicts could be utilized to promote drug abuse prevention, but that their use should be carefully explored. The danger of glamorizing the ex-addict's past life by young persons must be carefully avoided in this type of program.

In the Commission's opinion, educational programs on drug abuse in our schools and communities leave much to be desired. A reevaluation of the drug user as he relates to the school institution should be done based on fact presented in the community survey. This process should be investigated jointly by the County and school districts, and new and more effective techniques of preventive education should be developed.

Recommendations

The County of Montgomery should become instrumental in assisting local school districts to implement the following recommendations:

1. The County of Montgomery should create a centralized organization, in conjunction with school officials, to become responsible for the creating of meaningful drug abuse curriculums for both the schools and communities. In both cases, this organization should serve to provide appropriate programs and pull together all segments of the community (religious leaders, parents, police, health officials, social and political leaders, teachers, counselors) for involvement. Continuous and ongoing educational seminars should be provided to all persons living in the community so that a gradual informed body of knowledge will begin to emerge among all members concerned with drug abuse of both a legal and illegal nature.

2. It has become apparent to the Commission that this concluded study has only just begun to shed factual knowledge on the drug problem. It is thus strongly recommended that further drug-related research be conducted by both the public and private sectors of Montgomery County.

3. Drug information centers should be started at local levels to provide information that reflects that community's needs. These centers should be locally controlled but coordinated with County and state sources. If possible, they should be integrated into existing community agencies such as community drug umbrella groups, schools, hospitals, halfway houses or centers, and the young themselves should be utilized to staff and run them.

4. Lack of relevant activities, employment, and meaningful school involvement by young people in the community have consistently been cited as causal factors for drug use. Development of programs offering alternates to drug use must be provided at all local levels. Local political, educational, and social institutions must begin to create alternates within the system which offer the young a contributing share of the system. If this occurs, the young themselves can become one of the most potent resources against drug abuse.

a. Schools should open their facilities for relevant youth programs during the evenings and weekends.

b. The school should promote parent-child drug educational sessions to strengthen the parent-child identity with each other and with the institution.

c. Uniform rules and regulations about drug abuse in all County schools should be developed in the parent-child group sessions with overall guidance being provided by the administrations.

d. Community social agencies and schools should encourage peer lay counseling and referral services as they relate to drug use in schools.

e. Local governmental units should promote low cost jobs with limited community responsibility in such areas as ecology and other youth concerned problems.

5. It is recommended that to reach those parents who never communicate with the school, the following approach should be instituted:

   a. All Home and School Visitors should be thoroughly trained about drug abuse, causality, and sociological facts related to drug abuse and the psychological makeup of drug abusers.

   b. The Home and School Visitor should then be assigned to work with the isolated family when the child in question has been identified as a potential drug user by the school counselor.

   c. Every attempt possible, including personal visits, should be made to get at least one parent of every school child actively involved in the drug abuse programs. This is especially critical at the middle and upper school levels.

6. Local youth councils should be formed in every community to act as an advisory board to local school, government, and social bodies. The youth, after all, are an important interest group and should be listened to when decisions about their future are being made. To continue to alienate young people

from our social institutions is to continue feeding the flames of drug abuse.

7. Colleges and universities must be encouraged to initiate drug abuse courses for their students. Every student teacher presently in college should be given extensive training in the area of drug abuse before they graduate. Practicing teachers and counselors should either be directed to return to colleges offering a drug abuse course or be enrolled in training seminars offered by County sponsored programs.

LAW ENFORCEMENT

The Commission's Findings

In addition to the findings set forth in A Survey of Drug Usage and Abuse in Montgomery County, Pennsylvania (there is no significant relationship between availability of drugs and their use, other than marijuana in high school), the Commission has found that neither the police nor the courts alone have the resources or means to continue providing an effective defense against the growing infection of drug abuse. The Commission finds that these professionals, though properly attuned to the needs of addicted citizens, are often hampered by the very nature of their function. The Commission has found that those legal guidelines governing the actions of the police and courts are limited in both approaches and solutions to the problem. In essence, the police, courts, and defendants are often frustrated due to the system's inability to provide appropriate services to the abuser and community in which he lives. In most cases, the public resources available are unresponsive to the abuser's needs and enforcement's ability to respond in other directions are being hampered by restricted legislation, limited knowledge, and lack of unity between the community and themselves.

In view of these limits, enforcement has been unable to provide what they know to be appropriate priorities and services; and have, as a result, been unfairly criticized by the people they serve.

However, it is the feeling of the Drug Commission that enforcement at all levels does, and must continue to play a vital role in the struggle against drug abuse. With appropriate public support, education, facilities, legislation, and factually based priorities their services can continue to be one of the most vital resources available in reducing the volume of drug abuse.

To accomplish this, the enforcement bodies and the public which they serve must reevaluate their position against drug abuse; and in doing so, must join together in formulating appropriate roles and levels of responsibility based on a common commitment. For too long, the enforcement bodies of our County have been charged with the total responsibility of solving the drug abuse menace, and for the public to continue ignoring their own responsibilities can only lend to further hostilities, ineffectiveness, and eventual failure.

Recommendations

Judiciary

That the County of Montgomery become instrumental in assisting the courts to implement the following recommendations:

1. The intrinsic relationship between offense and disposition have a significant effect on the future behavior of any given drug defendant. Specific recommendations should be set forth dealing with narcotic offenses so that drug defendants may be effectively dealt with as soon as possible.
2. The President Judge of the Montgomery County Courts should select one or more judges to hear only narcotic cases during any given session of criminal court. If

necessary, additional sessions of court time should be made available to expedite case backlogs.

3. In-service drug educational programs should be provided on a regular basis to those judges assigned to narcotic cases so they can learn more about the drug abuser and the components that go into making up the reasons for his behavior. In addition, the County should make available to the courts a current listing of programs available for their use and a mechanism by which constant feedback can be presented on persons sent to those facilities.

4. The auxiliary services of the court; namely, juvenile and adult probation, should be increased in staff size according to the number of corresponding drug dispositions. This growth should be designed in the following manner:

   a. That all supervision probation officers be directed to formulate, within their existing caseloads, a drug abuser unit. This section should not increase existing case numbers and additional officers should be employed to offset this.

   b. That within this unit, no more than 20 drug cases should be assigned to any one probation officer.

   c. That those probation officers engaged in drug rehabilitation be provided with an in-service educational program on drug abuse, causality, and the psychological makeup of drug abusers.

5. It is also recommended that the number of public defenders be increased to avoid court delays and permit proper time for case preparations in drug matters.

District Attorney

That the County of Montgomery assist the District Attorney to implement the following recommendations:

1. To reorganize the County narcotics unit into a centralized division. This unit would, on a full-time basis and in cooperation with local police departments, perform in the following areas:

a. To continue to deal with the curtailment of drug traffic in Montgomery County.

b. To work towards acquiring legislation which would allow them to assist in inspecting and policing legitimate drug producers and suppliers that are located within the County.

c. To augment local police efforts in their attempts to control and investigate drug activities within their area.

d. To coordinate information and investigate drug activities with surrounding counties as well as state and federal authorities.

It is further recommended that this strike force of narcotic specialists be composed in the following manner:

a. Consist of sufficient personnel to adequately cover the entire County.

b. That each member of that unit receive specialized education in the areas of drug abuse, causality, and drug treatment.

It is further recommended by the Commission that to assist in dealing with this problem, the County of Montgomery provide the following:

1. That the County of Montgomery implement plans for a crime laboratory to assist the local police, district attorney, and courts in their narcotic investigations. The facility should provide the following services:

   a. Capacity to analyze all narcotic, nonnarcotic, and other chemical substances within 24 hours.

   b. Capacity to analyze blood urine samples for narcotics within 24 hours.

   c. Capacity to analyze the total range of criminal evidence from fingerprints to bullet and gun identification.

   d. To identify, upon anonymous citizen request, the identification of unknown substances for parents and other concerned citizens in the County.

2. That the District Attorney's Office increase the number of assistant district attornies who specialize in drug investigation and prosecution, and that these assistants receive similar education in the areas of causality, drug abuse, and treatment.

3. That a centralized statistical criminal unit be developed to collect and provide information on criminal activity in all communities of Montgomery County.

Local Police

That the County of Montgomery provide assistance to its local police forces in the following areas:

1. To encourage the continuous development of police-community unity, cooperation, and coordination as it relates to the drug abuse problem with specific emphasis being given to lines of responsibility and preventive alternatives to enforcement arrest.

2. Provide all local police officers with a basic working knowledge of drug abuse, its affect on drug users, and sociological factors which create them by providing continuing inservice training seminars at the Montgomery County Community College or similar facility.

3. To create in each police department, or in conjunction with another department, a full-time narcotics specialist who would work directly with the centralized narcotics division as well as on local narcotic problems.

4. That the County of Montgomery sponsor and provide funds or technical assistance to all local police departments in acquiring staffing funds for narcotic specialists if their budget does not permit obtainment of additional personnel.

5. That these narcotic specialists be qualified, not only to investigate drug cases, but also to assume a leadership role in community awareness and prevention of drug usage.

MARIJUANA

The Commission's Findings

The findings of the Drug Commission on the subject of marijuana are not as conclusive as anticipated. Information on the subject matter has not been fully documented. It does not lend itself to substantial facts which can be dealt with in a positive constructive manner.

The Commission, however cites three aspects of the marijuana dilemma for consideration:

1. Marijuana is a physically and psychologically destructive force, and the present laws concerning it should be retained and enforced.

2. Legalization of the drug, on the basis that it is not any more harmful or deadly than alcohol, may be a valid argument. Legalization would take the drug out of the illegal drug culture environment where other more dangerous drugs are readily available.

3. A somewhat compromising stance is that the laws for the abuse of marijuana should be separated from that of the "hard" drugs; that marijuana should not be legalized, but the laws governing its use and possession should reflect a more liberal approach. This view is based on some research (undocumented to any great degree) that shows that the drug cannot be proven either safe or unsafe for most consumers at this time.

As the Commission attempted to delve into this question and to develop recommendations for a course of action, one stumbling block kept arising: Not enough was known about the drug's long-term effects. The Commission concluded that the final answer to the question lies in the medical and psychological research now being conducted by various independent and governmental organizations. A course of action can be dictated once the medico-psychology profession has made known the true, scientific facts concerning marijuana. Action in the form of prevention will never be successful as long as it is based on scare tactics.

The Commission has found that marijuana is used basically as a psycho-support mechanism. This support is used generally by the younger generation between the ages of 12 and 25. Their reasons for the use of marijuana as a support are not very different from their reasons for the use of alcohol. The substances are very different in form, but the psychological predisposition to its use are very similar.

There are a number of different reasons for youngsters' use of marijuana: boredom, search for excitement, family problems, peer group pressure, puberty rites, and adolescent rebellion.

Recommendations

In view of the information available, the Drug Commission recommends that:

1. Marijuana should not be legalized. Because of insufficient facts on both sides of the controversy, more research is needed about the long-range effects of marijuana on the human psychology and physiology.

2. The penalties for use and possession of marijuana, first offense, should be reduced from a felony to a summary offense and subject to the following action:

    a. A first offender should be treated as a summary proceedings with the case being disposed of before a district justice.

    b. A penalty imposed by the district justice of a fine not to exceed $100.

    c. The Commission recognizes that a district justice is not a court of record and also recognizes that there must be some record in order to determine whether an individual is a first offender or a multiple offender. Legislation should provide for a central record-keeping arrangement from which one could determine the number of offenses of each individual.

3. The penalties for marijuana possession on a second offense should be reduced from a felony to a misdemeanor and subject to the following if found guilty:

    a. A second offense should be treated as a misdemeanor.

    b. Required to complete a prescribed course on drug abuse.

    c. Subject to a fine by the court not to exceed $500.

    d. Any of the above.

TREATMENT & REHABILITATION

The Commission's Findings

The Drug Commission finds that the County of Montgomery is in severe need of drug treatment and rehabilitation services at all levels. At present, Eagleville Hospital is the only facility in the entire County that is equipped to treat drug abusers on a comprehensive level. In essence, the need for service among citizens using drugs is far greater than the County's capacity to service those needs.

In the Commission's opinion, there are five basic elements necessary for a comprehensive drug treatment and rehabilitation service. All proposed or existing treatment programs should reflect in some form these components if they are to engage in treatment:

1. Detoxification Unit

   The provision of a medical treatment unit which can provide initial services for those persons who are entering the first phase of physical and psychological drug withdrawal.

2. Inpatient and Outpatient Therapies

   The provision of both inpatient and outpatient facilities offering therapy and other treatment techniques and supportive services designed to effect a change or growth in behavioral patterns of the abuser.

3. Positive Control and Discipline

   The development of a continuous system of checks and controls on a patient's acting out behaviors while in treatment to ensure that a drug free life style is occurring which is in line with treatment objectives.

4. Community Resocialization and Vocational Development

   The provision of an ongoing process of resocialization and vocational development which will enable the patient to reenter society in a useful and rewarding way and reenforce treatment goals and accomplishments.

5. Post Treatment Follow-Up and Evaluation

   The continuous process of discharged patient follow-up and supportive treatment should be provided to ensure that they do not return to addictive patterns of behavior. A continuous program of evaluation should also be systematically provided to measure the overall effectiveness of the treatment program.

The Drug Commission further finds that to effectively implement a County-wide drug treatment service, an appropriate organizational model must be developed. This organizational model must have two basic elements if it is going to be effective. These elements are funding resources and flexibility:

1. Funding Resources

   To successfully provide drug programs, one must have access to funding sources that recognize the model. It is quite clear that local treatment programs would be hard pressed if they were totally dependent on local contributions and fees. Thus, the organizational model must be able to meet the local demands for services by funding a variety of program structures with federal, state, and County funds.

2. Flexibility

   In addition to qualifying and providing funds, the organizational model must be able to create and support various types of programs in any given community. Sufficient evidence has been given to demonstrate that the traditional medical model for treatment of drug abuse is limited in its effectiveness, and often too far removed from the causes of the problem to become more effective. Many essential programs in prevention, referral, and early treatment do not fall within the medical model and would in fact become useless if they did fit. Grass roots programs that function in the street, providing lay counseling and prevention alternates to drug use, are examples of these programs.

The Commission finds that no one program or treatment approach will meet the needs of all persons afflicted with drug abuse. A variety of treatment approaches must be developed. Though these may differ, their services must be coordinated and a cooperative inter-program attitude maintained. Joint intake procedures should be developed for patient intake and appropriate procedures for treatment crossover of patients must be created.

The Commission also finds that various programs have begun to operate in the County, but at this time they are limited in both services and funds. At all levels, programs are in embryonic stages of development and will have to grow considerably before they become totally effective. The need to coordinate and facilitate growth in various programs is a real necessity if meaningful services are going to be forthcoming.

Recommendations

It is recommended that the County of Montgomery assume the responsibility for implementing the following services:

1. The formation of a central organizational model at the County level, such as the Mental Health- Mental Retardation Board, should be directed to provide the following services:

   a. To work with all community based programs, such as CODAC, in planning, developing, and coordinating drug abuse services.

   b. To function as a funding resource.

   c. To stimulate and encourage local development of new drug treatment programs within the structure of existing treatment services as well as the creation of new ones.

   d. To act as a referral and information center.

   e. To evaluate existing and proposed treatment programs for drug abuse in the County.

2. To immediately formulate a 24-hour emergency reception center that would accept from all parts of Montgomery County, persons in need of care due to drug usage or related psychological disturbance. Specifically, this service should provide:

   a. Immediate medical and psychological care to anyone brought to the service on a 24-hour basis.

   b. Temporary residential quarters which could range from one hour to five days.

   c. An immediate medical and psychological evaluation.

   d. Referral and implementation of an appropriate treatment plan following the crisis services.

3. The formation of community based detoxification centers in local hospitals around Montgomery County to provide medical detoxing services to drug abusers referred by the emergency reception center or other treatment services. If these units cannot be formulated immediately, the County should institute a centralized detoxification unit run by the MH-MR Board but coordinated with and connected into all existing drug treatment programs.

4. The formation of a County based residential treatment program to deal with adolescent drug users. This service should, in addition to treating the adolescent, also be staffed to involve the parents in the treatment process.

5. The formation of an outpatient methadone treatment program to meet the needs of heroin addicts who have failed to respond in drug free programs or who are medically determined to be most suited for this type of treatment. It is further recommended that this program be based on the following guidelines:

    a. That it accept at any given time no more than 200 active patients.

    b. That these patients be thoroughly screened and offered methadone only as a last treatment resource.

    c. That a sophisticated research design be built into the program to assess its effects and usefulness.

    d. That the program offer, in addition to methadone, a total array of services including psychotherapy, vocational counseling, and training.

    e. That the maximum time for methadone usage be one year and that at the end of that year, the addict be released or rechanneled into drug free therapy for further evaluation to determine if he can function without methadone.

6. To develop a County organizational model which will utilize multi-treatment drug abuse approaches in which to treat a drug abuser as he moves through the various rehabilitation tracks.

7. To formulate group living facilities to provide shelter and supportive care to recovering drug abuse patients, parole, and probation drug offenders and juvenile drug offenders who are declared emancipated minors on both a short-term crisis basis and long-term residential basis.

8. To encourage all local hospitals to provide emergency treatment beds for drug abusers until they can be released or transferred to the emergency reception center for further evaluation and referral.

9. To provide funds to existing outpatient treatment facilities such as the MH-MR Base Service Units to provide additional treatment staff trained in the area of drug addiction so that appropriate outpatient treatment can be provided after detoxification or ongoing treatment to patient reentering the community from drug treatment programs.

10. To encourage local communities to work towards identifying the problems of drug abuse in their area and to provide yearly grants for community grass roots programs which are providing services in the areas of prevention, identification, referral, lay counseling, and recreation.

11. To work towards legislative changes which would mandate the Pennsylvania Unemployment offices and the Bureau of Vocational Rehabilitation to provide additional funds and trained caseworkers to assist the recovered addict population in vocational resettlement.

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MONTGOMERY COUNTY

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"They conquer who believe they can."

--Virgil